

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08212					08205				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
THOMAS (NMN) BENTON					June 3, 1969			1:15 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		08-9-86		82 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A.				Carroll			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville		Springfield State Hospital		Musician & Laborer		Factory			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Baltimore City		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		107 Warren Avenue			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address	
William H. Benton		Jennie Day		No		213-20-0019 Unknown		Records, Springfield State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Possible Myocardial Infarct								minutes	
DUE TO, OR AS A CONSEQUENCE OF									
(b) Generalized Arteriosclerosis								years	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-19-51, 19__, to 6-3-69, 19__, that (I) (we) last saw the deceased alive on 6-3-69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
Octavio Ruiz, M.D.		6-3-69		Octavio Ruiz, M.D.		Springfield State Hospital Sykesville, Maryland 21784			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/5/69		Oak Lawn Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Schimunek Funeral Home, Inc. 3331 Brehms Lane				JUN 6 1969		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

08213				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
Item 23 Film 44 7/18/69 kk				CERTIFICATE OF DEATH			
08206							
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gamber</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gamber</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RD 2 Finksburg, Md.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Grace</b> First <b>Louisa</b> Middle <b>Brauning</b> Last				4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1969</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1881</b>		9. AGE (In years last birthday) yrs. <b>88</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elias Shilling</b>				14. MOTHER'S MAIDEN NAME <b>Emma Jane Davis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. David T. Young RD 2 Finksburg, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO <b>Hyper-tensive-cardio-vascular</b> (b) <b>apneic bronch disease</b> DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-1-1940</b> to <b>6-28-69</b> , that (I) (we) last saw the deceased alive on <b>6-28-69</b> , and that death occurred at <b>7:45 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>James B. Saffell</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6-28-69</b>	
22c. PHYSICIAN'S NAME (Type) <b>James B. Saffell</b>				22d. ADDRESS <b>Ruckus Farm Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 2, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Providence Church Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Gamber Carroll Md.</b>	
24. FUNERAL DIRECTOR <b>Thomas D. Fletcher</b>				25. REC'D BY REGISTRAR <b>JUL 8 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>	

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THE UNIVERSITY OF CHICAGO

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "University" and "Chicago" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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08214

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

08207

1. DECEASED-NAME (Type or print) <b>Cora</b>			First Middle Last <b>- Brooks</b>			2a. DATE OF DEATH <b>6</b> Month <b>20</b> Day <b>69</b> Year			2b. HOUR <b>2:30</b> PM		
3. SEX <b>female</b>			4. RACE <b>Negro</b>			5. DATE OF BIRTH <b>5/23/77</b>			6. AGE (In years and birthday) <b>92</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Carroll</b>		
10. CITY OR TOWN OF DEATH <b>Rural--Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. CITY OR TOWN <b>Baltimore</b>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>519 Lanvale Street</b>		
14. FATHER'S NAME <b>William</b>			15. MOTHER'S MAIDEN NAME <b>Eliza</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>			16b. SOCIAL SECURITY NO. <b>220-54-6310T</b>		
17. INFORMANT <b>Springfield Hospital records, Sykesville, Md.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>4270</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9/26/1963</b> to <b>6/20/1969</b> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>6/20/1969</b> and that in <b>our</b> opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <b>not</b> view the body after death.											
22b. SIGNATURE <b>Naci N. Buyukunsal, M.D.</b>						22c. DATE SIGNED <b>6/20/69</b>					
22d. PHYSICIAN'S NAME (Type) <b>Naci N. Buyukunsal, M.D.</b>						22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>6-21-69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes Cemetery</b>			23d. LOCATION (City or town) (County) (State) <b>Sykesville Md.</b>		
24. FUNERAL DIRECTOR <b>Harry W. Haight</b>						25a. REC'D BY REGISTRAR <b>JUN 25 1969</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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08215

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08208

1. DECEASED-NAME (Type or print) <b>Core L. Caldwell</b>			2a. DATE OF DEATH <b>JUNE</b> Month <b>18</b> Day <b>1969</b> Year		2b. HOUR <b>11 PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>March 24, 1888</b>		6. AGE (In years last birthday) <b>81</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>York Co. Pa.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Carroll</b> Md.		
10. CITY OR TOWN OF DEATH <b>Westminster</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Co. Hospt.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Manchester</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Rt. 1</b>	
14. FATHER'S NAME First Middle Last <b>James Shenk</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Kathryn Burkholder</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>178-16-3080</b>	17. INFORMANT Address <b>Howard E. Caldwell Rt. 1 Manchester, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Generalized arteriosclerosis</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>June 4, 1969</b> , to <b>June 18, 1969</b> , that (I) (we) last saw the deceased alive on <b>June 18, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John S. Harshey, MD</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>6/18/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSHEY, MD</b>		22e. ADDRESS <b>8 Archer St. Westminster, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>June 21, 1969</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Manchester, Md.</b>	
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 23 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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## CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A M		
LEWIS			WI	LLIAM	CLAS	JUNE 20, 1969			8:50		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		White		7-30-1886		82 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Carroll Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hospital			Retired (farmer)					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSURE? <input checked="" type="checkbox"/> NO <input type="checkbox"/> LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Carroll		Manchester				Maplegrove Road		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Charles					Clas	Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
No			218-32-5900A			Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>										Days	
403X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										Days	
(b) <u>Uremia</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Renal failure due to nephrosclerosis</u>										Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CBS assoc. with <u>reaction</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>5-9-69</u> , 19 <u>69</u> , to <u>6-20-69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-20-69</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. Antonius Glahn</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>6/20/69</u>			
22d. PHYSICIAN'S NAME (Type) Antonius Glahn, M. D.						22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784					
23a. BURIAL, CREMATION, REINTERMENT (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)	(State)	
Burial		June 23, 1969		Immanuel Cemetery			Manchester, Md.				
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home				ADDRESS Hampstead, Md.		25a. REC'D BY REGISTRAR DATE JUN 23 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Can you find the book which is  
bound in the library

W. H. C. 1000

W. H. C. 1000

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08217

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08210

1 DECEASED NAME (Type or Print) <b>MARY AMANDA</b>			First Middle Last <b>CLICK</b>			2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year <b>June 1 1969</b>			2b HOUR <b>M</b>				
3 SEX <b>F</b>		4 RACE <b>W</b>		5 DATE OF BIRTH <b>FEB. 1, 1901</b>		6 AGE (In years last birthday) <b>68 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (State or foreign country) <b>PENNA.</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>CARROLL CO.</b>				
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <b>CARROLL CO. GENERAL</b>				12a U.S.A. OCCUPATION (Kind of work done during most of working life even if retired.) <b>Housewife</b>				12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD.</b>				13b COUNTY <b>CARROLL</b>		13c CITY OR TOWN <b>WESTMINSTER</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>MEADOW BRANCH RD.</b>			
14 FATHER'S NAME First Middle Last <b>BERNARD ECKENRODE</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>MARY MYERS</b>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16b SOCIAL SECURITY NO <b>213-18-9963</b>		17. INFORMANT <b>EARL N. Click</b>			ADDRESS <b>Same as above</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fracture of skull</b>											<b>1 3/4 hrs</b>		
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Auto Accident</b>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year <b>HOUS. A.M. 6-13 1969</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Auto Accident</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) <b>Street</b>			21f. LOCATION Street or R.F.D. No City or Town County State <b>Meadow Branch Road &amp; Rte 97</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Maurice C. Porter</b>			EXAMINER'S NAME (Type) <b>MAURILE C. PORTER, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>6-15-69</b>				
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
						ADDRESS (Street, city, town, or county) <b>HAMPSTEAD, MD</b>							
23a. BURIAL, CREMATION, or other disposal <b>Burial</b>			23b. DATE <b>6/18/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. VIEW CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>EMMITSBURG MD.</b>					
24. FUNERAL DIRECTOR <b>L. E. Myers, Jr., Westminster, Md.</b>			25a. REC'D BY REGISTRAR <b>JUN 18 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



08211

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) <b>Kate</b>		First		Middle		Last		2c DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1969</b>		2b. HOUR <b>5:40</b> M	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>Aug 30, 1880</b>				6 AGE (In years last birthday) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <b>Balto Md</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>				2b. HOUR <b>5:40</b> M	
10. CITY OR TOWN OF DEATH <b>Manchester, Md</b>		11 NAME OF HOSPITAL OR INST. TUTION (if not in hospital give street address) <b>Louisa Home</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased admission) STATE <b>MD</b>		13b. COUNTY <b>Baltimore Co</b>		13c CITY OR TOWN <b>Hampstead</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>Louisa</b>			
14 FATHER'S NAME First <b>Malvin</b> Middle <b>Gooden</b> Last <b>Frank D. Resh</b>		15 MOTHER'S MAIDEN NAME First <b>Adella</b> Middle <b>Armacost</b> Last									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO <b>216-46-3881</b>		17 INFORMANT <b>Kathryn Miller</b>		Address <b>Hampstead, Md</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>41</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>antemortem Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN</b> <b>5 yrs</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)							
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or RFD No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>7/3</b> , 19 <b>67</b> , to <b>6/28</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>6/27</b> , 19 <b>69</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>W H Foard</b>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <b>6/28/69</b>					
22d PHYSICIAN'S NAME (Type) <b>W. H. Foard MD</b>		22e ADDRESS <b>Manchester, Md</b>									
23a BURIAL CREMATION, Burial (Specify)		23b DATE <b>July 1, 1969</b>		23c NAME OF CEMETERY OR CREMATORY <b>Grace Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Hampstead Balto. Md.</b>					
24 FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>		ADDRESS		25a REC'D BY REGISTRAR <b>101</b> DATE <b>7 1969</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

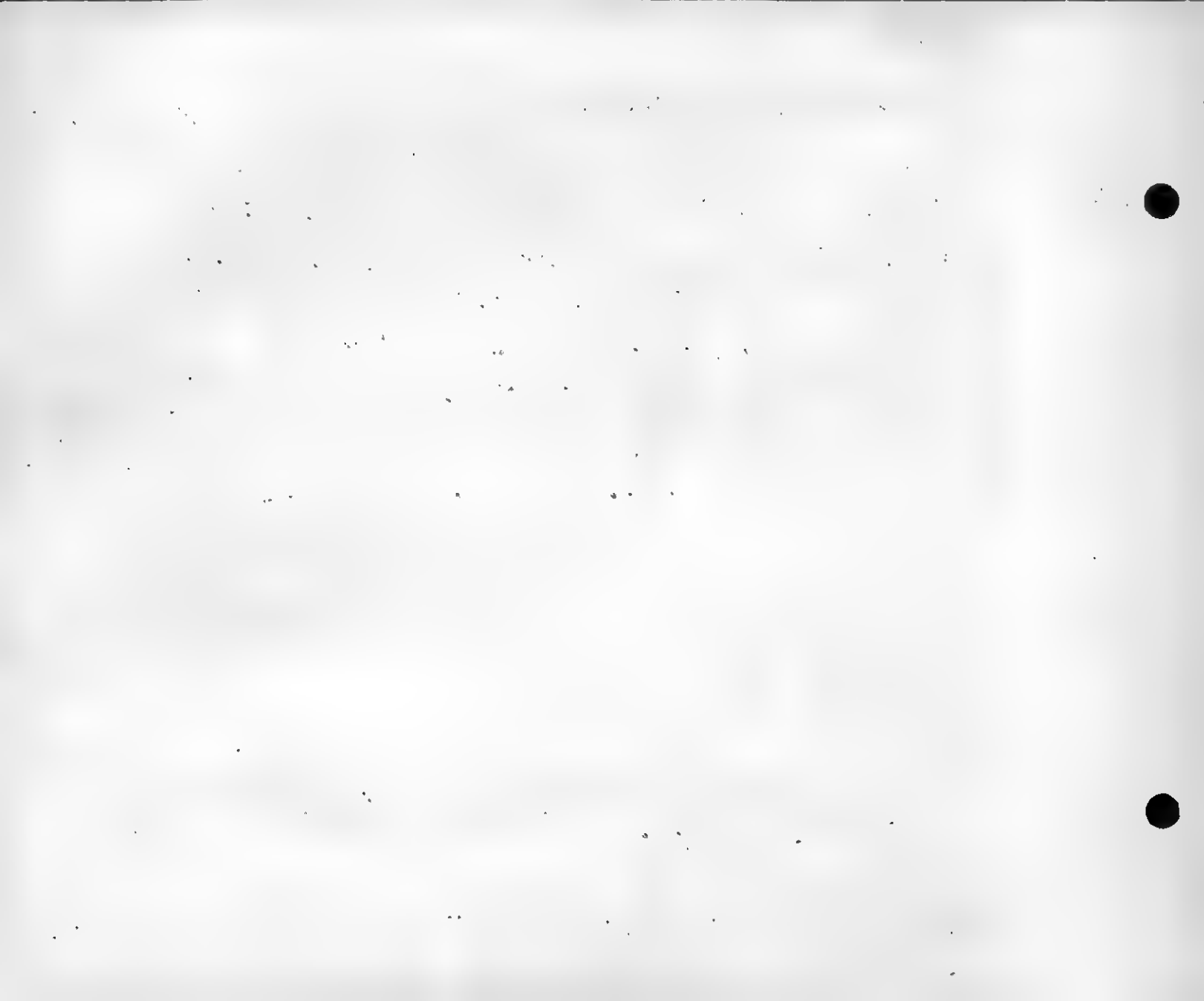




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08219		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08212	
1. DECEASED-NAME (Type or print) First Middle Last <b>MAMIE ELIZABETH DIX</b>						2a. DATE OF DEATH Month Day Year <b>6 28 69</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>FEB. 3, 1894</b>		6. AGE (In years lost birthday) <b>75</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL Co.</b>	
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>OLD WASHINGTON RD.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSE - WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>RUFUS MONTGOMERY HORNE</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>LIZZIE NEFF</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <b>Yes, no, or unknown</b>			
16b. SOCIAL SECURITY NO. <b>220-30 77 708</b>		17. INFORMANT <b>TANDY A. DIX</b>		Address <b>SAME ADDRESS</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Pulmonary Tuberculosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio Sclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>1 year</b>						PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>5-4</b> , 19 <b>63</b> , to <b>6-28</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>6-28</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death, <b>checkers said in my absence</b> )							
22b. SIGNATURE <b>William Peinker</b>		22c. PHYSICIAN'S NAME (Type) <b>—</b>		22d. ADDRESS <b>—</b>		22e. DATE SIGNED <b>6/30/69</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>7/1/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN MEM. GARDENS</b>		23d. LOCATION (City or Town) (County) (State) <b>FINKSBURG MD</b>	
24. FUNERAL DIRECTOR <b>S. S. Myers Jr., Westminster, Md.</b>		25a. REC'D BY REGISTRAR <b>—</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JUL 2 1969</b>	



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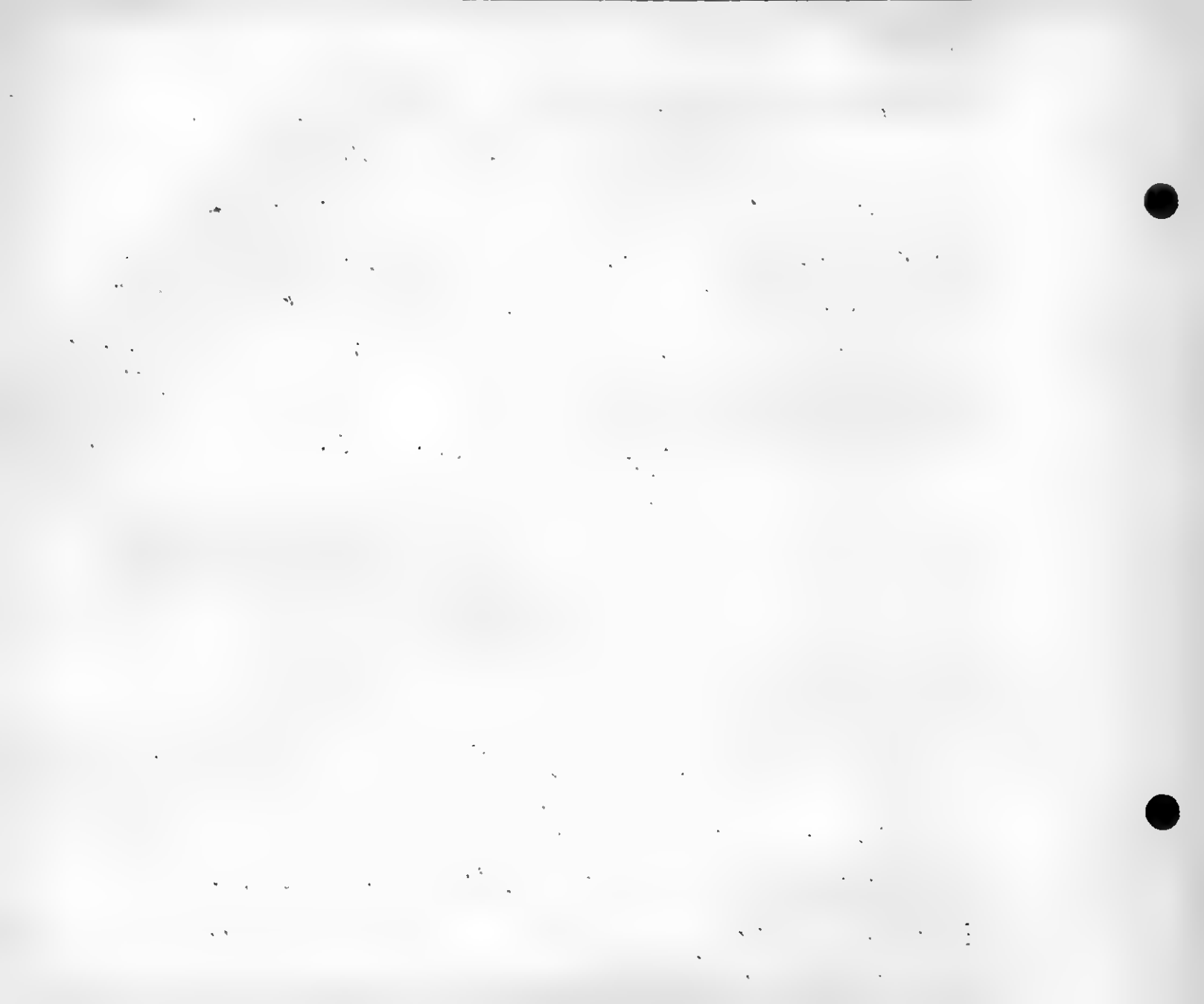
08220

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08213

1. DECEASED-NAME (Type or print) <b>MAYMIE ELIZABETH EDITH DIXON</b>			2a. DATE OF DEATH Month <b>JUNE</b> Day <b>11</b> Year <b>69</b>			2b. HOUR <b>12:15</b> A.M.	
3. SEX <b>FEMALE</b>		4. RACE <b>COLORED</b>		5. DATE OF BIRTH <b>JULY 4, 1905</b>		6. AGE (In years last birthday) <b>63</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL CO.</b> Md.	
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>36 CHARLES ST</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSE-WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (Where deceased lived; if institution, residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME First <b>SIMEON</b> Middle <b>JOHNSON</b> Last <b>ELLSIE</b>		15. MOTHER'S MAIDEN NAME First <b>DUNSON</b> Middle <b>ELLSIE</b> Last <b>DUNSON</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-32-3654</b>	
17. INFORMANT <b>THOMAS A. DIXON</b>		Address <b>SAME ADDRESS</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Lungs (Metastatic)</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cachexia &amp; Anemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>6 months</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5-6 yrs</b> <b>6 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from <b>11-5-64, 1964</b> , to <b>6-11, 1969</b> , that (I) (we) last saw the deceased alive on <b>6-10, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (any) (did not) view the body after death.	
22b. SIGNATURE <b>W. Glenn Speicher</b>		22c. DATE SIGNED <b>6-11-69</b>		22d. PHYSICIAN'S NAME (Type) <b>W. GLENN SPEICHER, M.D.</b>		22e. ADDRESS <b>W. GLENN SPEICHER, M.D., 1111 N. W. 11th St., Ft. Lauderdale, Fla.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6/14/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT JOY CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>UNIONTOWN CARROLL, MD</b>	
24. FUNERAL DIRECTOR <b>J. S. Myers, Jr., Westminster, Md.</b>		25a. RECD BY REGISTRAR <b>JUN 13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>JUN 13 1969</b>	



4349

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>08221</div> <div>CERTIFICATE OF DEATH</div> <div>08214</div>									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
BARBARA			(NMN)			DONOHUE			Month Day Year JUNE 5, 1969
3. SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		7-22-17			51 YRS		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH
Maryland			U.S.A.						Carroll Md
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Sykesville			Springfield State Hospital			None			
13a USLA. RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY (IN TS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Maryland			Baltimore City			Baltimore			13e STREET AND NUMBER 1646 Jackson St.
14 FATHER'S NAME			First Middle Last			5 MOTHER'S MAIDEN NAME			First Middle Last
John			J. Blottenberger			Anna			M. Carlisle
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.			17 INFORMANT Address			
No			-----			Records, Springfield State Hospital			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) of heart due to embolism.									minutes
DUE TO, OR AS A CONSEQUENCE OF Infarcts in right hemisphere of brain due to embolism.									less than a day.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			HOUR A.M. Month Day Year P.M. 19						
21d INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC			21f. LOCATION Street or R.F.D. No City or Town County State			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from 10-11-34, 19__, to 6-5-69, 19__, that (I) (we) lost saw the deceased alive on 6-5-69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE						DEGREE		22c DATE SIGNED	
Dr. Antonius Glahn, M.D.						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		6-5-69	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
Antonius Glahn, M.D.						Springfield State Hospital Sykesville, Maryland 21784			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)
Burial			6 7 69			Glen Haven			Glen Burnie, A. A. Co. Md.
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Mc Cully			130 E. Fort Ave			JUN 9 1969		Charles Judge	

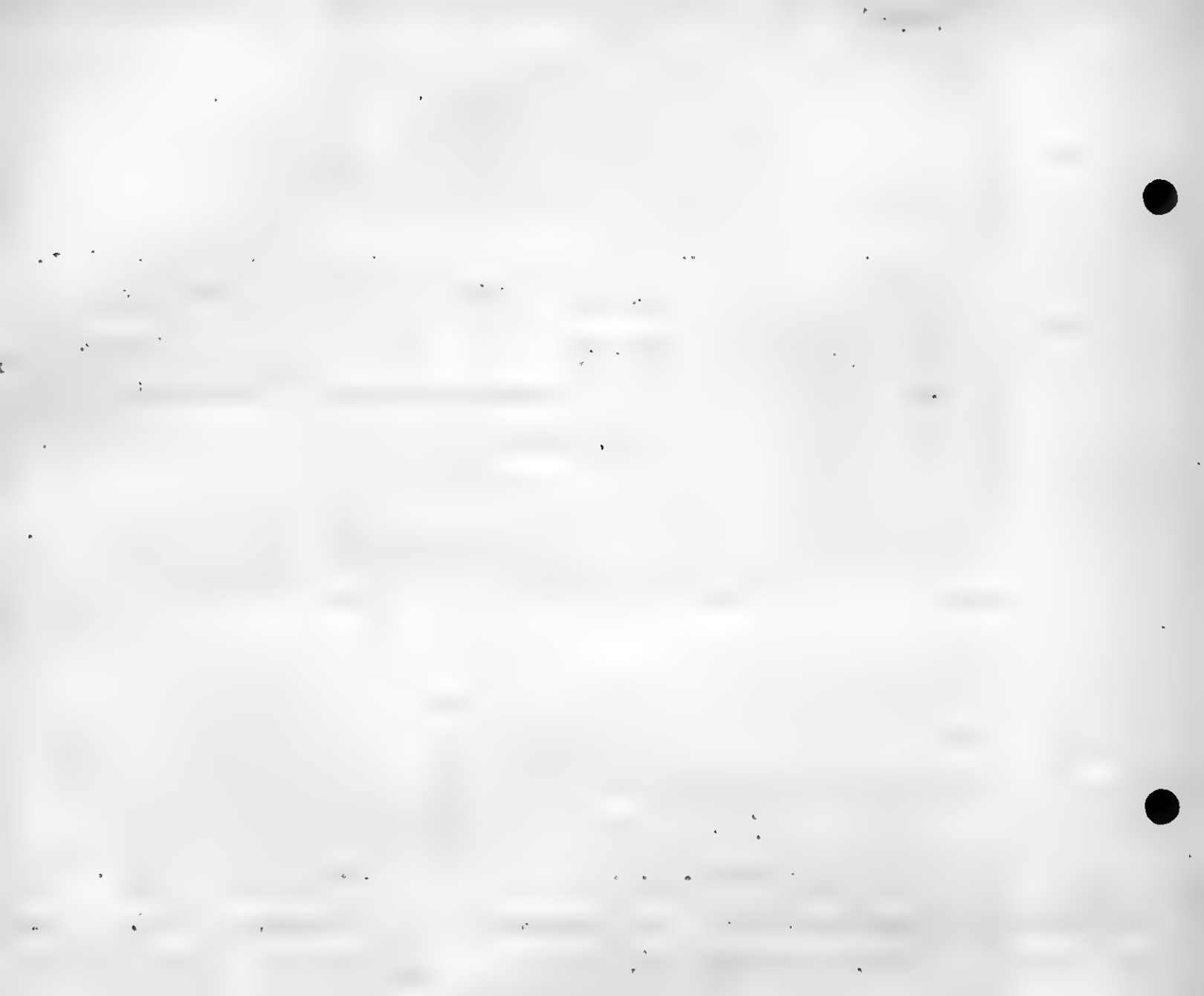




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08222		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08215	
Item 14 Film 413 6/18/69 kk					
1. DECEASED-NAME (Type or print) First Middle Last JESSIE W. DORSEY			2a. DATE OF DEATH 6 Month 6 Day 69 Year		2b. HOUR 3:28 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 6-26-1878		6. AGE (In years last birthday) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH CARROLL Md.		
10. CITY OR TOWN OF DEATH STYKESVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. give street address) PULLEN NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Howard	13c. CITY OR TOWN ELLIOTT CITY	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 8099 PARK DR.	
14. FATHER'S NAME First Middle Last AMERICUS Souder DORSEY	15. MOTHER'S MAIDEN NAME First Middle Last WATERS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		
16b. SOCIAL SECURITY NO.		17. INFORMANT Snowdon Dorsey 8099 Park Dr. Elliott City			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Edema 4124 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) CASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 10 yrs. 20 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from May 5, 1969, to June 5, 1969, that (I) (we) last saw the deceased alive on June 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Sani Okutman		DEGREE M.D.		22c. DATE SIGNED 6/6/69	
22d. PHYSICIAN'S NAME (Type) Sani Okutman, M.D.		22e. ADDRESS Obrecht Rd., Sykesville, Md. 21784			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-9-69	23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) (State) Woodlawn Balto., Md.	
24. FUNERAL DIRECTOR Higginbotham-Slack Elliott City, Md.		25a. REC'D BY REGISTRAR JUN 11 1969		25b. REGISTRAR'S SIGNATURE M. J. Judge	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 2043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										Film G413 6/20/69kk	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										08216	
1. DECEASED NAME (Type or Print) <b>STANLEY A. ERICKSON</b>						2a. DATE KNOWN OF DEATH Month <b>6</b> Day <b>11</b> Year <b>1969</b>		2b. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Aug 19 1924</b>		6. AGE (In years last birthday) <b>44</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.		2c. DATE PRONOUNCED DEAD Month <b>June</b> Day <b>11</b> Year <b>1969</b>	
7a. BIRTHPLACE (State or foreign country) <b>MINN.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b>		2d. HOUR <b>8:00 P.M.</b>			
10. CITY OR TOWN OF DEATH <b>Westminster</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3 East Main - Apt. 5</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Merchant Seaman</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, an. Residence before admission) STATE <b>MD.</b>				13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Westminster</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3 E. Main - Apt. 5</b>	
14. FATHER'S NAME First <b>EMILE</b> Middle <b>ERICKSON</b> Last <b>AGNES</b>				15. MOTHER'S MAIDEN NAME First <b>AGNES</b> Middle <b>FREEBURG</b> Last <b>FREEBURG</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16b. SOCIAL SECURITY NO <b>470-26-0682</b>		17. INFORMANT <b>MRS. GRACE E. WARREN</b>		ADDRESS <b>3 E. MAIN ST. WESTMINSTER, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fatty metamorphosis of liver</b>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year HOUR A.M. <b>19</b> P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
EXAMINER'S SIGNATURE <b>Charles S. Springate, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED <b>June 12, 1969</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>				23b. DATE <b>6/12/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. SALEM CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>MAHONIA CARROLLTON MINN.</b>			
24. FUNERAL DIRECTOR <b>J. S. Myers, Jr., Westminster, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>JUN 16 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
08224					08217					
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR			
First Middle Last Marion Hoppel Fiery					6 Month 12 Day 69 Year		9:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		
female		white		7/15/96		72 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Carroll Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Rural--Sykesville			Springfield State Hospital			Librarian				
13a. USUAL RESIDENCE (Where deceased lived, if institution)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6206 Mossway	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
First Middle Last John - Fiery					First Middle Last Susan Sue - Hoppel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
no			212-42-7328		Springfield Hospital records, Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage									1 day	
4310 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension									years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Schizophrenic reaction, chronic undifferentiated type. CBS with cerebral arteriosclerosis.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from 9/26/1966 to 6/12/1969, that (X) (we) last saw the deceased alive on 6/12/1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.										
22b. SIGNATURE				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED				
Jose L. Chapulle, M.D.						6/12/69				
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
				Springfield State Hospital Sykesville, Maryland						
23a. BURIAL (CREMATION, REMOVAL) (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6-14-1969		Rose Hill Cemetery		Hagerstown, Maryland				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
Wm. Cook-Brooks Towson 1050 York Rd. 21204				JUN 16 1969						





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4100

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Lula			C. Fleming			Month 6 Day 2 Year 69		5 a.m.	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS	
Female		White		Jan. 8, 1890		79 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Carroll Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Woodbine		Route 1		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission), STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Carroll		Woodbine		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 1	
14. FATHER'S NAME			First Middle Last			15. MOTHER'S M.A.DEN NAME First Middle Last			
Jeff			Campbell			Loretta			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
No			yes		Raymond O. Fleming Same As #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>									<u>Sudden</u>
4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>HASCVD</u>									<u>10 yrs.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Heart Failure</u>									<u>10 yrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>CA of nose</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 22</u> , 19 <u>69</u> , to <u>June 2</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May 22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Sani Okutman</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>June 2, 1969</u>			
22d. PHYSICIAN'S NAME (Type) <u>Sani Okutman, M.D.</u>				22e. ADDRESS <u>Obrecht Road, Sykesville, Md. 21781</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Burial</u>		<u>6/5/1969</u>		<u>Morgan Chapel</u>		<u>Carroll, Md.</u>			
24. FUNERAL DIRECTOR: ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
<u>C. M. Waltz, Box 241, Sykesville, Md.</u>				<u>JUN 5 1969</u>		<u>Charles Judson</u>			



4364

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

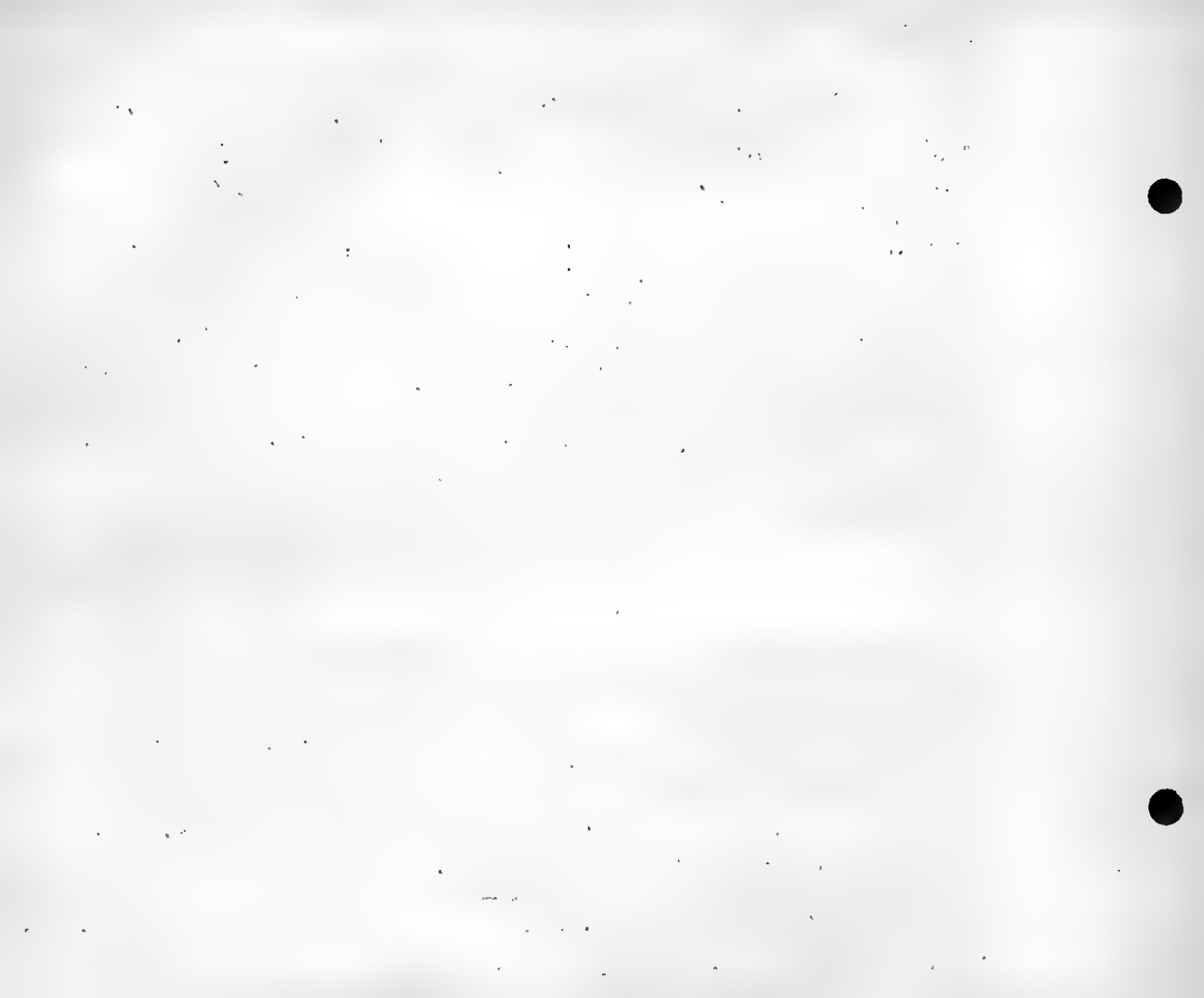
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08226

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

08219

1. DECEASED-NAME (Type or print) <b>RAYmond D. Flickinger</b>			2a. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>1969</b>			2b. HOUR <b>9:20</b> M							
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7063-1886</b>		6. AGE (In years lost birthday) <b>83</b> YRS		7. UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>			
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.							
10. CITY OR TOWN OF DEATH <b>MANCHESTER</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give street address) <b>Louisa View Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>FARMER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>FARMER</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>MD</b>			13b. COUNTY <b>Carroll</b>			13c. CITY OR TOWN <b>NEW WINDSOR</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>RFD 2</b>	
14. FATHER'S NAME First <b>R. F. W.</b> Middle <b>F.</b> Last <b>Flickinger</b>			15. MOTHER'S MAIDEN NAME First <b>Olivia</b> Middle <b>Albany</b> Last <b>h</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO <b>220-342341</b>			17. INFORMANT <b>Mrs. Raymond Flickinger</b> Address <b>Flickinger, New Windsor, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>6/29</b> , 1969, to <b>6/29</b> , 1969, that (I) (we) last saw the deceased alive on <b>6/29</b> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>W. H. Foard, MD</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>6/29/69</b>				
22d. PHYSICIAN'S NAME (Type) <b>W. H. Foard MD</b>						22e. ADDRESS <b>MANCHESTER, MD 21102</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>7/2/1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope</b>			23d. LOCATION (City or Town) (County) (State) <b>Woodshoro, Frederick, Md.</b>				
24. FUNERAL DIRECTOR <b>C. M. Waltz, Box 241, Sykesville, Md.</b>						25a. REC'D BY REGISTRAR <b>JUL 2 1969</b>			25b. REGISTRAR'S SIGNATURE <b>J. S. Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1  
30M REV. 1/58

08227		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08220	
1. DECEASED NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR	
First Middle Last Mattie May Towble				Month Day Year 6 12 69		9 30 A.M.	
3. SEX Female		4. RACE white		5. DATE OF BIRTH 3-1-1882		6. AGE (In years last birthday) 87 YRS.	
7a. BIRTHPLACE (State or foreign country) md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.	
10. CITY OR TOWN OF DEATH Manchester		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Longmear Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE md.		13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead		13d. INSIDE CITY, LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 367 N. Main St.		14. FATHER'S NAME First Middle Last Thomas Martin		15. MOTHER'S MAIDEN NAME First Middle Last Laura Hampshire		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown	
16b. SOCIAL SECURITY NO. 215-48-8243		17. INFORMANT Address 367 Main St. Hampstead		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 10, 1966, to Jan 12, 1969, that (I) (we) last saw the deceased alive on Jan 12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph E. Buck M.D.		22c. PHYSICIAN'S NAME (Type) Joseph E. Buck M.D.		22d. ADDRESS Hampstead, Maryland		22e. DATE SIGNED Jan 12, 1969	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE June 15, 1969		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Greenmount Carroll Md.	
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.				25a. REC'D BY REGISTRAR JAN 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08228

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08221

1. DECEASED-NAME (Type or print) <b>RITA CATHERINE GARLITZ</b>			2a. DATE OF DEATH Month <b>6</b> Day <b>8</b> Year <b>69</b>			2b. HOUR <b>7:30 AM</b>					
3 SEX <b>F</b>		4 RACE <b>W</b>		5. DATE OF BIRTH <b>JUNE 29, 1918</b>		6 AGE (In years last birthday) <b>50</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>			
7a BIRTHPLACE (State or foreign country) <b>PA.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL CO.</b>					
10. CITY OR TOWN OF DEATH <b>NEW WINDSOR</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>RTH 1, Box 118</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD.</b>			13b COUNTY <b>GARRETT</b>			13c CITY OR TOWN <b>LONACONING</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>R.D. 1</b>	
14 FATHER'S NAME First <b>JOSEPH A.</b> Middle <b>A.</b> Last <b>FAY</b>			15. MOTHER'S MAIDEN NAME First <b>SPOHN</b> Middle <b>SPOHN</b> Last <b>SPOHN</b>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>			16b. SOCIAL SECURITY NO. <b>—</b>			17 INFORMANT <b>HARRY GARLITZ, R.D. 1, LONACONING, MD.</b>			Address <b>—</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Probable Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Exogenous alcohol</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic Phycosis Prob Mental retardation</b>											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If injury, notify medical examiner)			21b TIME OF INJURY HOUR A.M. <b>19</b> Month <b>6</b> Day <b>8</b> Year <b>69</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. <b>—</b> City or Town <b>—</b> County <b>—</b> State <b>—</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 19 <b>69</b> , to <b>June</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>June 6, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>William R. O'Rourke MD</b>			DEGREE <b>MD</b>			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>6/8/69</b>		
22d. PHYSICIAN'S NAME (Type) <b>WILLIAM R. O'ROURKE MD</b>			22e ADDRESS <b>W. MAIN ST. WESTMINSTER MD</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>6/11/69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>ST. ANN'S CHURCH CEM.</b>			23d. LOCATION (City or Town) (County) (State) <b>LONACONING GARRETT, MD</b>		
24. FUNERAL DIRECTOR <b>Kirk Newman, Grantville, Md.</b>			ADDRESS			25a. REC'D BY REGISTRAR <b>JUN 13 1969</b>			25b. REGISTRAR'S SIGNATURE <b>William R. O'Rourke</b>		



4369

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 5, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151  
30M REV 1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M
Florence			Thompson			June 1			1969
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female	White		Jan 2 - 1864			75 YRS			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Rose Hill, VA.			USA					Carroll	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Manchester			Long View Nursing Home			Homemaker			
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland			Carroll			Taneytown		R #1 17	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Floyd Thompson			Victoria Martin			DeBust			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			
No			217-12-2291			Antonio Lopez, Taneytown, Md			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cerebrovascular Accident									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Generalized Anteromedian									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 5/10, 1969, to 6/1, 1969, that (I) (we) last saw the deceased alive on 5/30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death.									
22b. SIGNATURE W. H. Ford M.D.						22c. DATE SIGNED 6/1/69			
22d. PHYSICIAN'S NAME (Type) W. H. Ford M.D.						22e. ADDRESS Manchester, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6-4-69		KEYSVILLE CEMETERY		KEYSVILLE, CARROLL, MD.			
24. FUNERAL DIRECTOR C. O. Foss & Son						25a. REC'D BY REGISTRAR JUN 3 1969		25b. REGISTRAR'S SIGNATURE M. J. Judge	



1  
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

<div> <div>08230</div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div> <div>08223</div> <div>08223</div> </div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore City 21211</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>						d. STREET ADDRESS <u>1127 W. 40<sup>th</sup> Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur</u> <u>LAWRENCE</u> <u>Gorsuch</u>						4. DATE OF DEATH <u>June</u> <u>27</u> <u>1969</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-16-11</u>		9. AGE (in years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>C.E. Parsons</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Walter Gorsuch, dec.</u>						14. MOTHER'S MAIDEN NAME <u>Charlotte Phillips, dec.</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-11-4347</u>		17. INFORMANT Address <u>Springfield State Hosp. Records</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Maurice C. Porterfield</u>						22. DATE SIGNED <u>6-28-69</u>					
EXAMINER'S NAME (Type) <u>MAURICE C. PORTERFIELD</u>						Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7/1/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Springs Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Howard Co., Md.</u>		
24. FUNERAL DIRECTOR <u>Ann Donovan - 3818 Roland Ave.</u>						25a. REC'D BY REGISTRAR <u>JUL 1 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



CERTIFICATE OF DEATH

08224

08231

1. DECEASED-NAME (Type or print)			First <b>Viola</b>	Middle <b>Irene</b>	Last <b>Grimes</b>	2a. DATE OF DEATH 6 Month 23 Day 69 Year			2b. HOUR AM PM 9:20 AM						
3. SEX <b>female</b>			4. RACE <b>white</b>		5. DATE OF BIRTH 8/15/99			6. AGE (in years last birthday) 69 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Carroll</b> Md						
10. CITY OR TOWN OF DEATH <b>Rural--Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY						
3a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Carroll</b>			13c. CITY OR TOWN <b>Sykesville</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>Route #2</b>			
14. FATHER'S NAME First <b>Thomas</b>			Middle <b>-</b>			Last <b>Franklin</b>			15. MOTHER'S MAIDEN NAME First <b>Rosie</b>			Middle <b>-</b>		Last <b>Young</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>			16b. SOCIAL SECURITY NO <b>218-11-0068</b>			17. INFORMANT Address <b>Springfield Hospital records, Sykesville, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive hemorrhage in pericardial sac</b> <b>141.0</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Perforated dissecting aneurysm of aorta</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic rheumatic and arteriosclerotic heart disease</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Months</b> <b>Years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.</b>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. ALTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (this hospital) attended the deceased from <b>1/13/1967</b> , to <b>6/23/1969</b> , that (I) (we) last saw the deceased alive on <b>6/23/1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.															
22b. SIGNATURE <i>Nacl N. Buyukunsal</i>			22c. DATE SIGNED <b>6/23/69</b>			22d. PHYSICIAN'S NAME (Type) <b>Nacl N. Buyukunsal, M.D.</b>									
22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>6/25/1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery Winfield, Carroll, Md.</b>			23d. LOCATION (City or Town) (County) (State)						
24. FUNERAL DIRECTOR <b>C. M. Waltz, Box 241, Sykesville, Md.</b>						25a. REC'D BY REG STRAR <b>JUN 26 1969</b>			25b. REGISTRAR'S SIGNATURE <i>K. Charles Judge</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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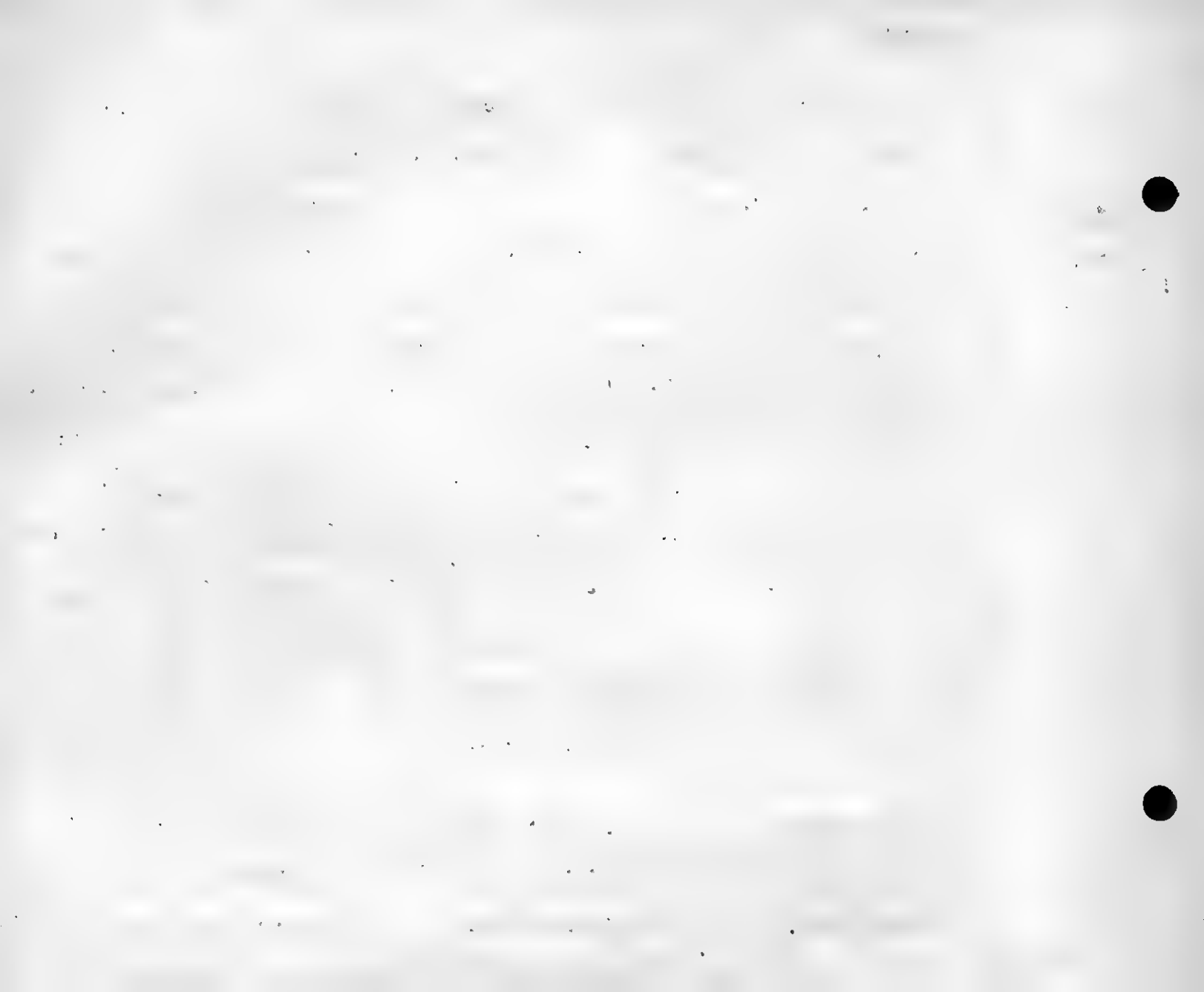
08232

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08225

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Rose				Harty	June Month 12 Day 1969 Year		3:45 PM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
Female	White		Sept. 16, 1882		86 YRS.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md		
Penna.	U.S.A.				Carroll County				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Taneytown		Crouse Mill Road		Housewife		Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Carroll		Taneytown				Crouse Mill Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Address Pa.	
John		Sarah		No		179-38-4372		Mrs. A.G. Robbins, 1139 Rittenhouse Rd. Phila.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u>								240	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio-Sclerosis Generalized</u>								5 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u>								7 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Sensitivity - Acute Glaucoma</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 1964, to June 12, 1969, that (I) (we) last saw the deceased alive on June 12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
E. Ambler Thompson, M.D.		6-12-69		E. Ambler Thompson, M.D.					
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS					
Taneytown, Maryland		Taneytown, Maryland		Taneytown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/14/69		Holy Cross Cemetery		Philadelphia Pa.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
C.O. Fuss & Son		June 16 1969		John H. Skiles					



4122

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH	
HERBERT							HORSEY		Month Day Year JUNE 18 69	
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		2b HOUR	
Male		Colored		Jan. 30, 1897			72 YRS.		8:15 PM	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland			U.S.A.					Carroll Md.		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Sykesville			Route 3			Laborer				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Carroll		Sykesville				Route 3	
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME First Middle Last	
Harvey							Horsey		Florence Johnson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT			Address	
No			220-01-34604			Mrs. Nina Horsey			Same As # 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4122 DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC FAILURE (LEFT VENT.) 2 HRS. (c) HYPERTENSIVE A.S.C.V.D. 10 YRS.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from JUNE 1969, to JUNE 1969, that (I) (we) last saw the deceased alive on JUNE 18 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Dr. R. V. Houch, Jr.						22c DATE SIGNED 6-18-69.		22d PHYSICIAN'S NAME (Type)		22e ADDRESS
Dr. R. V. Houch, Jr.						Liberty Rd., Sykesville, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			6/21/1969		Johnsville Cemetery			Johnsville, Carroll, Md.		
24 FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE
C. M. Waltz, Box 241, Sykesville, Md.								JUN 23 1969		Charles Young



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08234

CERTIFICATE OF DEATH

08227

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Henryton</b> c. LENGTH OF STAY IN 1b <b>2,448 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Henryton State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>6309 Banbury Road</b>	
3. NAME OF DECEASED (Type or print) <b>William Townsend Hughes</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1969</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-10-11</b>
9. AGE, in years (last birthday) <b>57</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Scott Hughes</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Wells</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Irving Wells, 6309 Banbury Road, Balto., Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Profuse bleeding upper GI Tract</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Recurrent Peptic ulcer</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental Retardation, congenital, severe</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-1-62</b> to <b>6-13-1969</b> , that (I) (we) last saw the deceased alive on <b>June 13, 1969</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edgars M. Maculans</b>		22b. DATE SIGNED <b>6-14-69</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, M. D.</b>		22d. ADDRESS <b>Henryton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 18, 1969</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burnie Sorensen, Towson, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 19 1969</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/60



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>082235</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>08228</div>												
1 DECEASED-NAME (Type or print)			First ARTHUR		Middle LEON		Last JOHNSON, SR.		2a. DATE OF DEATH Month 6 Day 4 Year 69		2b. HOUR P 11:00	
3 SEX Male			4. RACE Negro			5. DATE OF BIRTH 09/23/1882			6 AGE (In years last birthday) 96 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign county) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Carroll County			
10. CITY OR TOWN OF DEATH Sykesville			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) waiter			12b. KIND OF BUSINESS OR INDUSTRY Restaurant			
13a. USUAL RESIDENCE (Where deceased lived if institution admission) STATE Maryland			13b. CITY OR TOWN Baltimore			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 3031 Gwynn Falls Pkwy			
14 FATHER'S NAME First Middle Last unknown			5. MOTHER'S MAIDEN NAME First Middle Last unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) yes Navy WW I			16b. SOCIAL SECURITY NO 217-01-0711-A			17. INFORMANT Address Springfield State Hosp., Sykesville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (b) Pyelonephritis DUE TO, OR AS A CONSEQUENCE OF (c) Infected decubitus ulcers										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs. days/wks		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CRS assoc. with senile brain disease with psychotic reaction												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (he) (this hospital) attended the deceased from 09/06/67, 19 67, to 06/04, 19 69, that (he) (we) last saw the deceased alive on 06/04/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Milton H. Buschman, M.D.										22c. DATE SIGNED 6/5/69		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS Springfield State Hosp., Sykes., Md.									
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE 6-9-69			23c. NAME OF CEMETERY OR CREMATORY Arbutue Mem-Park			23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md			
24. FUNERAL DIRECTOR I.L. Brown & Son 108-W-Montgomery Street						25a. REC'D BY REGISTRAR JUN 10 1969			25b. REGISTRAR'S SIGNATURE Charles Judge			



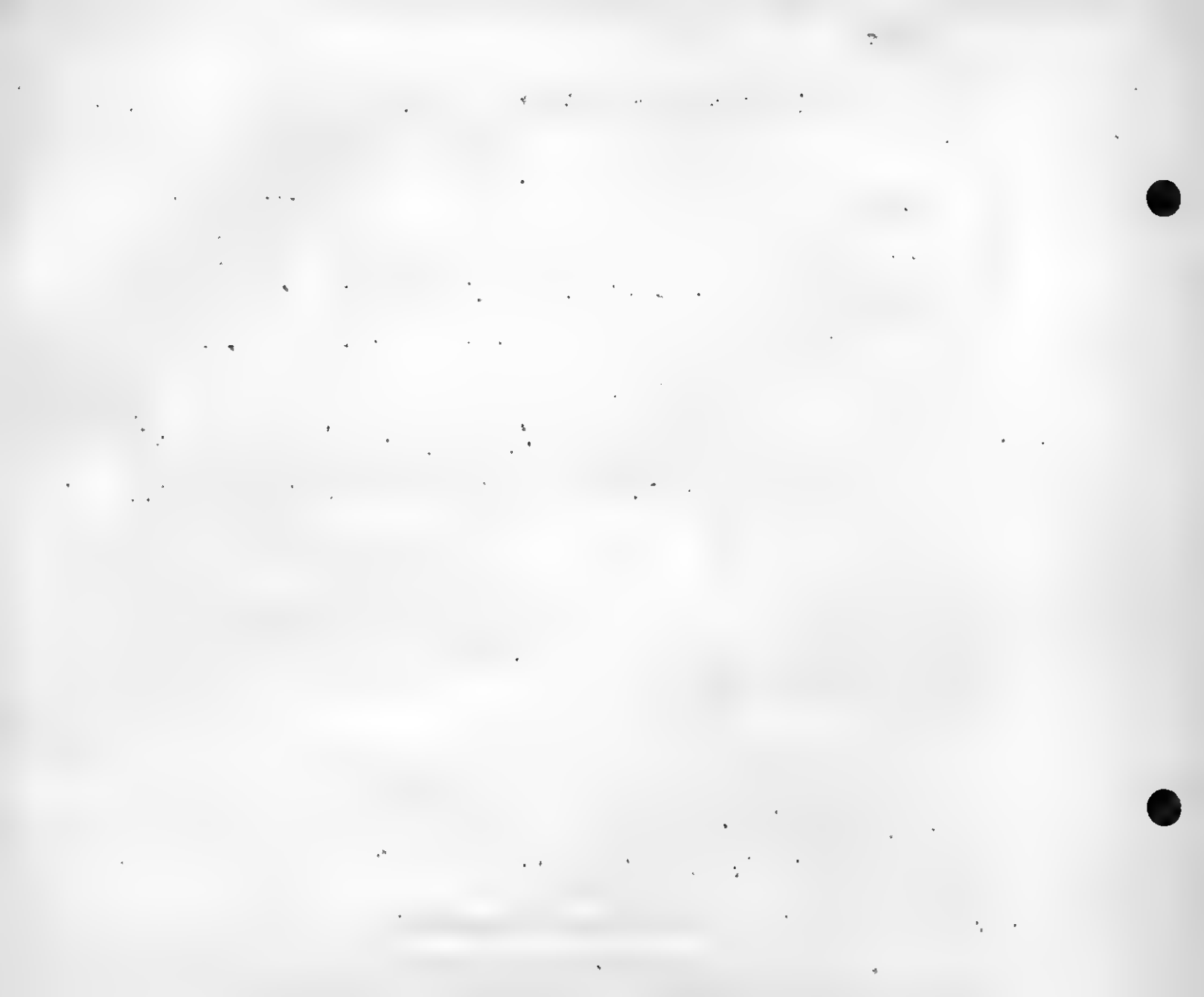


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

08236		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08229	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	
WILLIAM MURRAY KING						Month	Day
3 SEX			4 RACE		5 DATE OF BIRTH	6 AGE (In years last birthday)	7b. IF UNDER 1 YEAR
MALE			WHITE		SEPT 23, 1893	75 YRS.	MONTHS
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
MARYLAND			U.S.A.		9. COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
WESTMINSTER			RD # 2		WORKER FOR LUMBER COAL CO.		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER
MARYLAND			CARROLL		WESTMINSTER		RD # 2
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	
JACOB WESLEY KING						ANNIE A. E. MILLER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT		
NO			213-05-1719		MRS. CARRIE KOONTZ KING		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			ACUTE MYOCARDIAL INFARCTION				
4109							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) ARTERIO SCLEROTIC CARDIOVASCULAR 10 YEAR DIS				
DUE TO, OR AS A CONSEQUENCE OF							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
			HOUR A.M. Month Day Year				
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE			DEGREE			22c. DATE SIGNED	
Daniel I. Welliver						11 JUNE 1969	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS				
DANIEL I. WELLIVER			WESTMINSTER MD				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)
BURIAL			6/14/69		MEADOW BRANCH		WESTMINSTER MD.
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
J. E. Myers, Jr., Westminster, Md. 21157			JUN 13 1969			Johnnie Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08237		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08230	
Items #5&6, Film G111 7/11/69 km		CERTIFICATE OF DEATH			
1 DECEASED-NAME (Type or print) First Middle Last Albert Charles KLEIN			2a. DATE OF DEATH Month Day Year June 8, 1969		2b. HOUR 11 a.m.
3 SEX male	4. RACE white	5. DATE OF BIRTH 10-6-88/ 1882		6. AGE (in years last birthday) 81/86 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Carroll Md.		
10. CITY OR TOWN OF DEATH Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.		12a. USJA. OCCUPAT ON (Kind of work done during most of working life, even if retired.) Retired Signalman R.R.		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution address) STATE Maryland	13b. CITY OR TOWN Washington Co.	13c. CITY OR TOWN Hancock	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Pennsylvania Ave.	
14. FATHER'S NAME First Middle Last Albert Charles Klein		15. MOTHER'S M.A.DEN NAME First Middle Last Anna			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO 705-05-1748-A		17. INFORMANT Records Springfield State Hosp., Sykesville, Md.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))					
PART 1 DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia days DUE TO, OR AS A CONSEQUENCE OF (b) Acute + Chronic pyelonephritis week DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic heart disease Years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 5-27-69, 19, to 6-8-69, 19, that (I) (we) lost saw the deceased alive on 6-8-69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Octavio A. Ruiz M.D.		DEGREE M.D.		22c. DATE SIGNED 6-8-69	
22d. PHYSICIAN'S NAME (Type) Octavio Ruiz, M.D.		22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784			
23a. B. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-11-69	23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) Lawton W. Va.	
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md.		25a. REC'D BY REG. STRAR JUN 16 1969		25b. REGISTRAR'S SIGNATURE J. M. Jones	



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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
08238					08231					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH					
First Middle Last					Month Day Year 2b. HOUR					
William E. Liden					6 24 69 11:30 AM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		
Male		White		July 6, 1897		71 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.		U. S. A.				Carroll Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			CAK Street			Nursing		Hospital		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			CARROLL		Sykesville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		CAK Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Charlie - Liden			Annie - Trice							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No			218 34 0567		Mrs. Lucy Liden Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ruptured aneurysm (abdominal aorta)									1 hr.	
441.2 DUE TO, OR AS A CONSEQUENCE OF (b) Aneurysm of abdominal aorta									5 yrs.	
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis with hypertension 10 yrs.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April 15, 19 63, to June 24, 19 69, that (I) (we) last saw the deceased alive on June 24, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Sani Okutman					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED June 25, 1969			
22d. PHYSICIAN'S NAME (Type) Sani Okutman, M.D.					22e. ADDRESS Obrecht Rd., Sykesville, Md. 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6-27-69		Lakeview Cemetery		Sykesville, Md				
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md					25a. REC'D BY REGISTRAR JUN 30 1969		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08239					08232				
1 DECEASED NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last					Month Day Year			AM PM	
MARY EVELYN LINTHICUM					JUNE 12, 1969			9:10 AM	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (n years lost birthday)		7. UNDER 1 YEAR MONTHS DAYS	
Female		White		5-1-13		56 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Carroll Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville		Springfield State Hospital		Waitress					
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		427 Gaither Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Clarence		Poole		Unk.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No		220-26-4298		Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic failure									Years
DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis of liver									Years
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic alcoholism									Years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 5-20-69, 19__, to 6-12-69, 19__, that (I) (we) last saw the deceased alive on 6-12-69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22d. DATE SIGNED			
Dr. Antonius Glahn, M.D.		Antonius Glahn, M.D.		Springfield State Hospital Sykesville, Maryland 21784		6-12-69			
23a. BURIAL, CREMATION, REMOVAL, ETC.		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 16 1969		Laytonsville		Laytonsville Mont. MD.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis H. Barber Laytonsville Md				JUN 16 1969		Charles Judge			



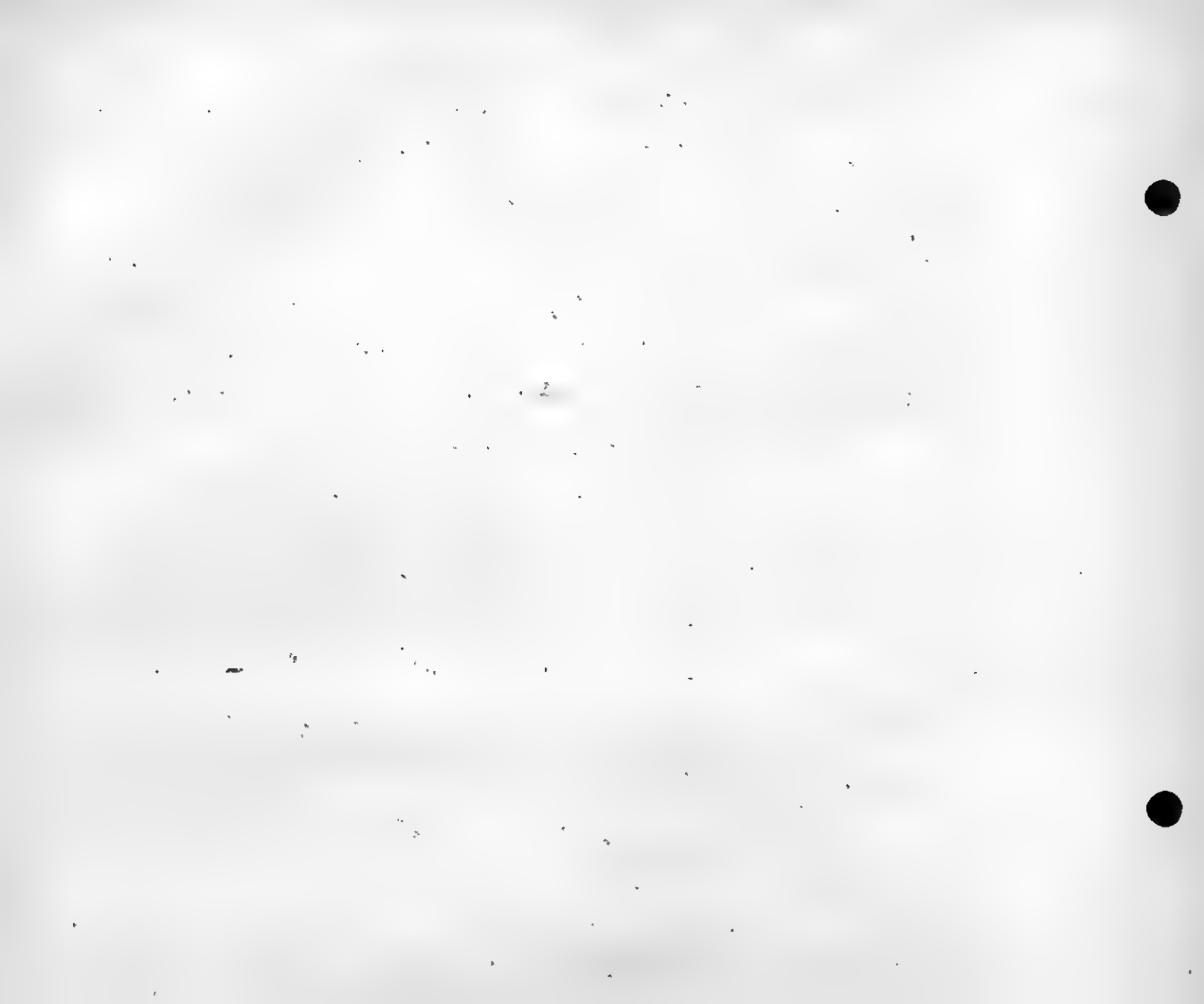


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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4134

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
08240					CERTIFICATE OF DEATH					08233				
1. DECEASED-NAME (Type or print) <u>Charles Wesley Martin</u>					2a. DATE OF DEATH <u>June 28 1969</u>					2b. HOUR <u>6:10 PM</u>				
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>April 2 1883</u>			6. AGE (in years last birthday) <u>86</u> YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Carroll</u> Md.								
10. CITY OR TOWN OF DEATH <u>Manchester</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Longview Nursing Home</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>FARMER</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>			13b. COUNTY <u>Carroll</u>		13c. CITY OR TOWN <u>Hampstead</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>108 Hucksville Ave</u>					
14. FATHER'S NAME First <u>Lewis</u> Middle <u>Martin</u> Last <u>Martin</u>			15. MOTHER'S MAIDEN NAME First <u>Mary Elizabeth</u> Middle <u>Keller</u> Last <u>Keller</u>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <u>NO</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <u>213-38-9451</u>			17. INFORMANT Address <u>Eva M. Bush Hampstead MD</u>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Advanced Emphysema Cor Pulmonale</u>														
19a. DATE OF OPERATION <u></u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u></u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u></u>								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u></u>			21f. LOCATION Street or R.F.D. No. City or Town County State <u></u>								
22a. I certify that (I) (this hospital) attended the deceased from <u>June 19 1967</u> , to <u>June 28 1969</u> , that (I) (we) lost the deceased alive on <u>June 28 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Joseph E. Bush MD</u> DEGREE <u>MD</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>June 28 1969</u>					
22d. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>						22e. ADDRESS <u>Hampstead Maryland</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>July 1, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grace Cemetery</u>			23d. LOCATION (City or Town) <u>Hampstead</u> (County) <u>Carroll</u> (State) <u>Md.</u>						
24. FUNERAL DIRECTOR <u>Tipton - Eline Funeral Home Hampstead, Md.</u> ADDRESS <u></u>						25a. REC'D BY REGISTRAR <u>JUL 7 1969</u> DATE			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <i>Lucy</i>			First <i>Ann</i> Middle <i>Mc Grane</i> Last			2a DATE OF DEATH Month <i>6</i> Day <i>5</i> Year <i>69</i>		2b HOUR <i>2:30</i> P.M.			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>May 31, 1900</i>		6 AGE (In years lost birthday) <i>69</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS M.W.			
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Carroll</i>		Md.			
10 CITY OR TOWN OF DEATH <i>Westminster</i>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Carroll Co. Gen. Hospt.</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before death) STATE <i>Md.</i>			13b COUNTY <i>Carroll</i>		13c CITY OR TOWN <i>Finksburg</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>Bloom Road</i>		
14 FATHER'S NAME <i>James</i>			First <i>Ellis</i> Middle Last			15 MOTHER'S MAIDEN NAME <i>Elizabeth</i>			First <i>Paine</i> Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b SOC. SEC. SECURITY NO. <i>219-12-9415</i>		17. INFORMANT <i>Mrs. Madeline Swan</i>			Address <i>Finksburg, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CEREBRAL THROMBOSIS</i> <i>4122</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>HYPERTENSIVE + ATHEROSCLEROTIC</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CARDIOVASCULAR DISEASE</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 WKS.</i> <i>YEARS</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>5/30, 1969</i> , to <i>6/5, 1969</i> , that (I) (we) last saw the deceased alive on <i>6/5, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>Vincent J. Brown Jr. MD</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <i>6/5/69</i>			
22d. PHYSICIAN'S NAME (Type)						22e ADDRESS					
23a B. RIAL CREMATION, PERMITS (Specify)			23b DATE <i>June 9, 69</i>		23c NAME OF CEMETERY OR CREMATORY <i>New Oakland Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Sykesville, Md.</i>				
24 FUNERAL DIRECTOR <i>J. T. Cline &amp; Sons</i>						ADDRESS <i>Reisterstown, Md.</i>		25a REC'D BY REGISTRAR DATE <i>JUN 9 1969</i>		25b REGISTRAR'S SIGNATURE <i>William S. Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Mabel I. MORAN						JUNE 23 1969			4:30 P.M.
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
Female	White		NOV. 15, 1887			81 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Carroll Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville			Springfield State			Typist			
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.					Baltimore				2405 Hamilton Ave.
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
William					Trotman	Amelia			Black
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
No			159-10-0901		Medical Records		Springfield State Hospital Sykesville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>									
4124 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CBS</u>									
<u>associated with senile brain disease with behavioral reaction</u>									
9a. DATE OF OPERATION			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 24, 1967</u> , to <u>June 23, 1969</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>June 23, 1969</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
<u>John C. Murphy, M.D.</u>			<u>6/23/69</u>						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
<u>John C. Murphy, M.D.</u>			<u>Springfield State Hospital Sykesville, Md.</u>						
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
<u>Burial</u>			<u>6/26/69.</u>		<u>Loudon Park Cemetery</u>		<u>Baltimore, Md.</u>		
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
<u>Leonard J. Ruck, Inc. Balto. Md. 21211</u>							<u>JUN 24 1969</u>		<u>John C. Murphy</u>



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08243

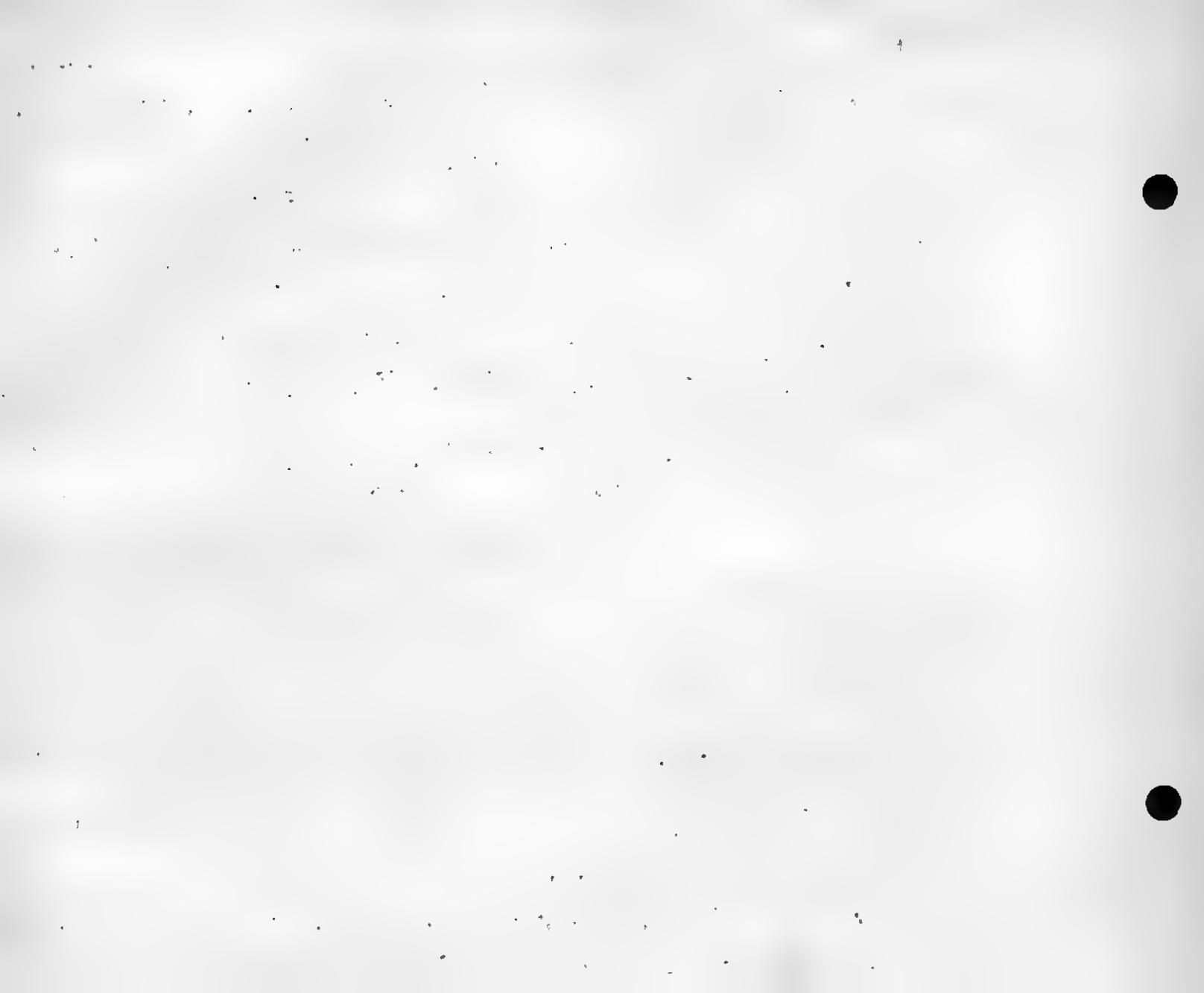
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08236

E.S.T.

1. DECEASED-NAME (Type or print) <b>LOYD OLIVER MYERS</b>			2a. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1969</b>			2b. HOUR <b>12:15</b> a.m.					
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>AUG. 10 1904</b>		6. AGE (In years last birthday) <b>64</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b>					
10. CITY OR TOWN OF DEATH <b>TANEYTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>YORK ST.</b>			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) <b>CANNING FACTORY</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>MEAT</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>TANEYTOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>YORK ST</b>		
14. FATHER'S NAME First <b>William</b> Middle <b>MYERS</b> Last <b>MYERS</b>			15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>SHANKER</b> Last <b>SHANKER</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>312-07-1426</b>		17. INFORMANT Address <b>MARIAN J. RICKETS Union Bridge</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>71</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs.</b> <b>15 yrs.</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Severe Emphysema</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <b>10 April</b> , 19 <b>44</b> , to <b>15 June</b> , 19 <b>69</b> , that (I) (we) saw the deceased alive on <b>7 June</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.											
22b. SIGNATURE <b>Robert S. McVaugh</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>15 June '69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Robert S. McVaugh M.D.</b>						22e. ADDRESS <b>Taneytown, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>JUNE 17</b>			23c. NAME OF CEMETERY OR CREMATORY <b>REFORMED CEM.</b>			23d. LOCATION (City or Town) (County) (State) <b>TANEYTOWN CARROLL MD</b>		
24. FUNERAL DIRECTOR <b>Union Bridge</b>						25a. REC'D BY REGISTRAR <b>JUN 19 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





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08244

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

08237

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
JOHN		WESLEY	NICHOLSON		Month 06 Day 18 Year 69		6:30 M		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male	White		04-15-99		70 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland	U.S.A.				Carroll Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville		Springfield State Hospital		Farmer					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Howard		Dayton				Linthicum Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John Richard Nicholson			Sarah Lucas						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT			
No				577-10-8112-A		Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY								days	
IMMEDIATE CAUSE (a) Heart Failure									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Arteriosclerotic cardiovascular disease.								years	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION		City or Town County State		
Where <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>					Street or R.F.D. No				
22a. I certify that (I) (this hospital) attended the deceased from 12-6-66, 19__, to 6-18-69, 19__, that (I) (we) lost saw the deceased alive on 6-18-69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Octavio A. Ruiz		6-18-69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Octavio Ruiz, M.D.		Springfield State Hospital							
		Sykesville, Maryland 21784							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6-20-69		Mt Zion		Highland, Howard Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Higinbotham-Slack		Ellie Cotton		JUN 20 1969					



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VR 1515 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
WILLIAM HARRISON OGG						JUNE 21 1969			9:30 AM
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (in years lost birthday)		7. IF UNDER 1 YEAR	
MALE	WHITE		JULY 5 1885			83 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		UNITED STATES				CARROLL Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
WESTMINSTER			R.F.D. #6			FARMER			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
MD.			CARROLL		WESTMINSTER		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.F.D. #6 BIRD VIEW ROAD.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
GEORGE N. OGG			LAURA FRANCES WILLIAMS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			
NO			214-03-739			ALBERT LEPP, SAME ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 4124 CONGESTIVE HEART FAILURE - 1 MONTH									
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR -									
DUE TO, OR AS A CONSEQUENCE OF (c) DIS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from JUNE 1965, to JUNE 1969, that (I) (we) lost saw the deceased alive on JUNE 21 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
DANIEL E. WELLIVER								6-21-69	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
DANIEL E. WELLIVER			WESTMINSTER MD						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		6/24/69		DEER PARK CEMETERY		SMALLWOOD CARROLL MD			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
J. S. Myers, Jr., Westminster, Md.			JUN 24 1969			Charles George			

4124



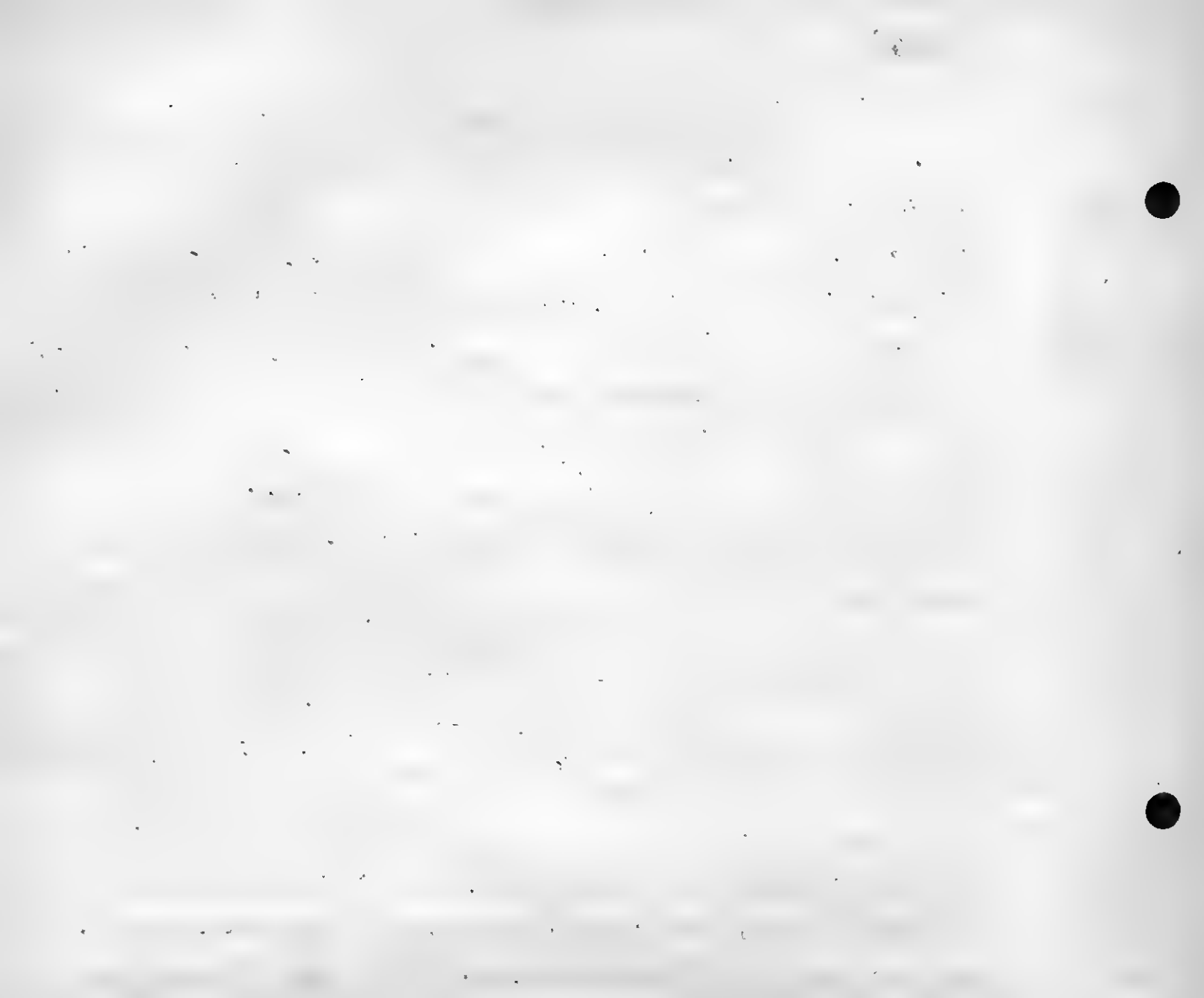
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1538

X 2 1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print) <b>BURNETT SULLIVAN ORMSTON</b>			First Middle Last			2a. DATE OF DEATH Month Day Year <b>JUNE 30 1969</b>			2b. HOUR <b>7:04 AM</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 12 1887</b>			6. AGE (In years last birthday) <b>82 YRS.</b>		7. UNDER YEAR MONTHS DAYS HOURS MIN		8. UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Carroll</b>				
10. CITY OR TOWN OF DEATH <b>Hampstead</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>218 N MAIN ST.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Telephone Operator</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>AT&amp;T Co.</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission to State) <b>Maryland</b>			13b. COUNTY <b>Carroll</b>			13c. CITY OR TOWN <b>Hampstead</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>218 N Main Street</b>	
14. FATHER'S NAME <b>HENRY</b>			First Middle Last			15. MOTHER'S M.A.DEN NAME <b>MARTHA ELLEN HOOVER</b>			First Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>212-03-6446A</b>			17. INFORMANT Address <b>Mrs Robert G Murray Hampstead Md</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Metastatic Carcinomatosis</b>													
153.8 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) <b>Primary Carcinoma of Colon.</b>													
DUE TO, OR AS A CONSEQUENCE OF													
(c) <b>Metastatic Carcinoma of Colon.</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>July 4, 1966</b> to <b>June 30, 1969</b> , that (I) (we) last saw the deceased alive on <b>June 28, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Joseph E Bush MD</b>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>JUNE 30 1969</b>				
22d. PHYSICIAN'S NAME (Type) <b>Joseph E Bush MD</b>			22e. ADDRESS <b>Hampstead Maryland</b>										
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>July 2, 1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Hampstead Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Hampstead Carroll Md.</b>				
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>						25a. REC'D BY REGISTRAR <b>JUL 7 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



08247

CERTIFICATE OF DEATH

08240

1 DECEASED-NAME (Type or print)		First Margaret	Middle Frances	Last Ruth	2a DATE OF DEATH Month Day Year 6 - 6 - 69		2b HOUR 10:30 PM
3 SEX female	4 RACE white		5 DATE OF BIRTH 5/7/83		6 AGE (In years at birthday) 86		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll		
10 CITY OR TOWN OF DEATH Rural--Sykesville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) saleslady		12b KIND OF BUSINESS OR INDUSTRY Sales	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 2764 The Alameda		14. FATHER'S NAME First Middle Last <del>XXXXXXXX</del> David Ruth					
15 MOTHER'S MAIDEN NAME First Middle Last <del>XXXXXXXX</del> Mary Hess		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no					
16b SOCIAL SECURITY NO 217-48-9791		17 INFORMANT Address Springfield Hospital records, Sykesville, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart failure 403X DUE TO, OR AS A CONSEQUENCE OF (b) Nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from 12/31/1968, to 6-6-1969, that (X) (we) last saw the deceased alive on 6-6-1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.							
22b. SIGNATURE Glorita Sagisi M.D.		DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-6-69			
22d PHYSICIAN'S NAME (Type) Glorita Sagisi		22e ADDRESS Springfield State Hospital Sykesville, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 6/10/69		23c NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto. 12, Md.		25a. REC'D BY REGISTRAR DATE JUN 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

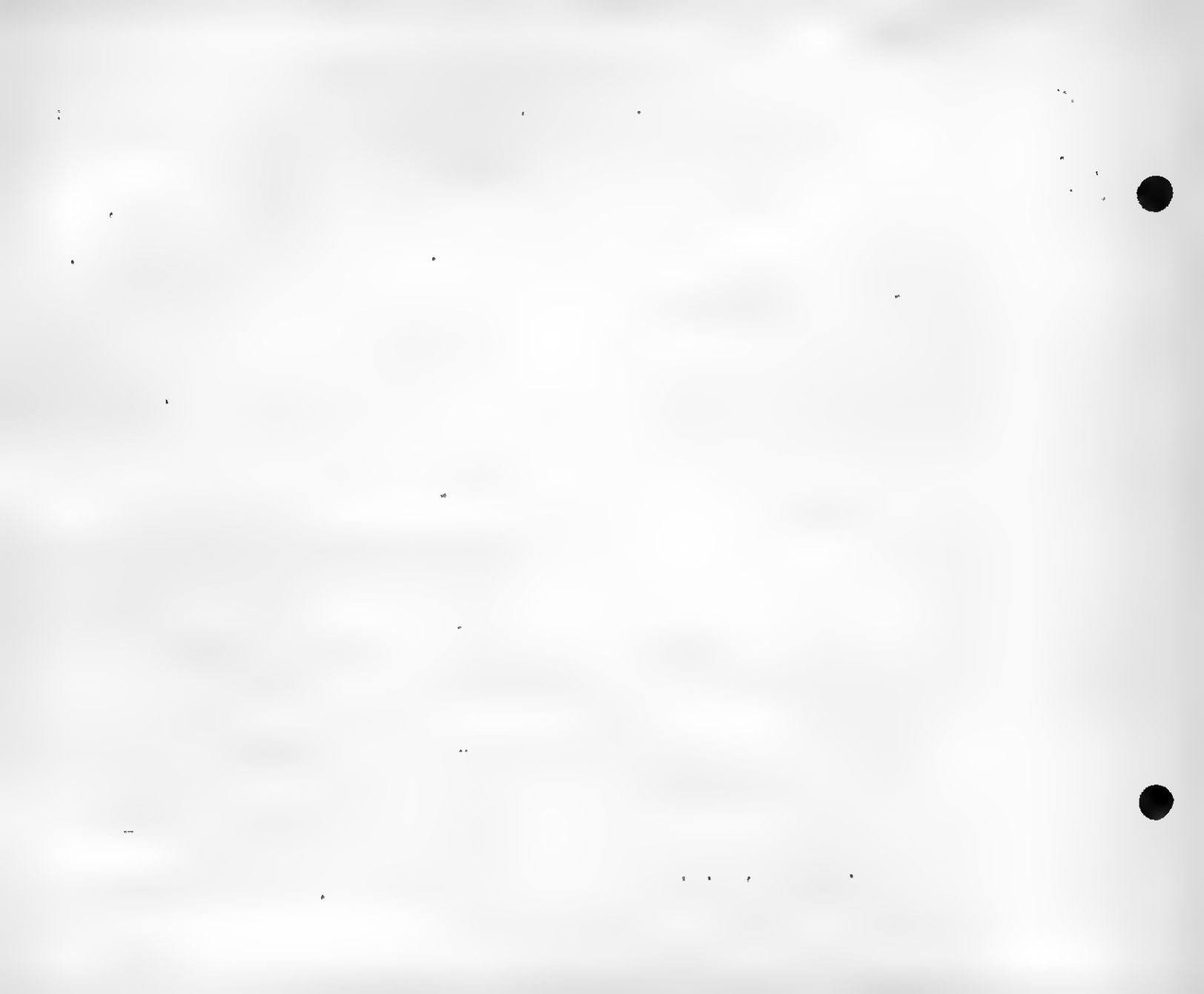




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08248		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08241	
Item 23 Film 413 6/20/69 kk		CERTIFICATE OF DEATH			
1 DECEASED-NAME (Type or print) First Middle Last		2a. DATE OF DEATH Month Day Year		2b. HOUR	
Leo E. St. Clair		6 13 69		5:15 M	
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7. UNDER 1 YEAR MONTHS
Male	White	10-26-07		61 YRS	IF UNDER 24 HRS HOURS MIN
7a BIRTH-PLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH		
Maryland	United States	Carroll County, Md			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY	
Sykesville	Springfield State Hosp.		Laborer	Unkn.	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LHM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER	
Maryland	Washington	Hagerstown	315 Ridge Avenue		
14 FATHER'S NAME First Middle Last	15 MOTHER'S MAIDEN NAME First Middle Last		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		
Unknown	Unknown		None		
17 INFORMANT		Address			
Springfield State Hospital records					
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		Months	
0937		DUE TO, OR AS A CONSEQUENCE OF		Years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Syphilitic aortitis.</u>			
		(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Bronchitis, Gynecomastia, 2nd degree neurosyphilis</u>					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from <u>9-24-</u> , 19 <u>41</u> , to <u>6-13</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>6-13-</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b SIGNATURE <u>G. Sagisi</u>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c DATE SIGNED <u>6-13-69</u>		
22d. PHYSICIAN'S NAME (Type) <u>G. Sagisi, M.D.</u>		22e ADDRESS <u>Springfield State Hospital</u>			
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE <u>6/17/69</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d LOCATION (City or Town) <u>Sykesville, Maryland</u>	23e (County) <u>Washington</u> (State) <u>Md.</u>	
24 FUNERAL DIRECTOR <u>Rouven F. Horne</u>		ADDRESS <u>305 N. Pot. St.</u>	25a REC'D BY REGISTRAR <u>JUN 17 1969</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV 11-68

08249

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08242

1. DECEASED NAME (Type or print) <b>EMMA N Sallisto</b>			2a. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1969</b>			2b. HOUR <b>5:15 P M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>3/28/1894</b>		6. AGE (In years last birthday) <b>75</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Cumwall</b> Md.	
10. CITY OR TOWN OF DEATH <b>MANCHESTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md</b>		13b. COUNTY <b>—</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER <b>2821 E Madison St</b>		14. FATHER'S NAME First <b>SAMPUL</b> Middle <b>FRANK</b> Last <b>MARY SIMMONS</b>		15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>SIMMONS</b> Last <b>S</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>(212-09-6402)</b>		17. INFORMANT <b>Vito Sallisto</b> Address <b>2821 E Madison St. Balt. Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>5 yrs</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Unknown Liver Secondary Anemia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/5</b> , 19 <b>69</b> , to <b>6/13</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>6/13</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>W.H. Foard M.D.</b>		DEGREE <b>—</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6/13/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>W. H. Foard MD</b>		22e. ADDRESS <b>MANCHESTER, MD 21103</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6-17-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Philip E. Smith</b>		ADDRESS <b>1211 Chesapeake Ave</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 17 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

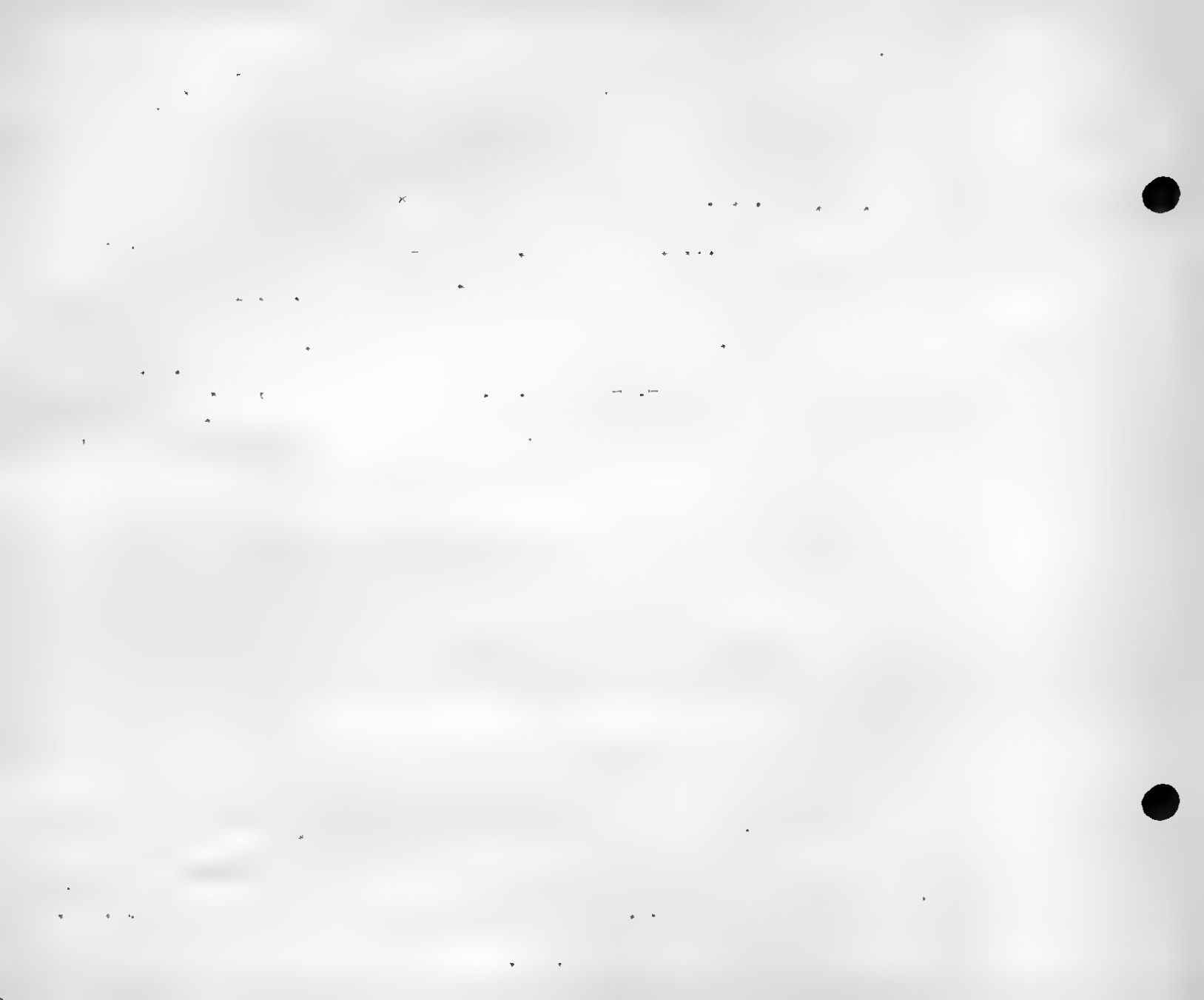
08250

08243

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3-Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First Middle Last		2a DATE KNOWN OF DEATH		Month Day Year		2b HOUR	
BERNARD PAUL SANDERS				10-21		1969		1:25 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 F UNDER 1 YEAR	8 F UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR	
Male	White	9/25/1911	57 YRS	MONTHS DAYS	HOURS MIN	Month 6 Day 21 Year 1969		3:30 PM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH			
Carroll Co., Md.		U.S.A.				Carroll		Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Westminster		D.O.A. Carroll Co. General Hospital		Millwork		Mill			
13a USUAL RESIDENCE (Where deceased lived, if institution)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		3e STREET AND NUMBER	
Maryland		Carroll		Westminster		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R. D. 1	
14 FATHER'S NAME		First Middle Last		15 MOTHER'S MAIDEN NAME		First Middle Last			
John J. Sanders				Annie S. Watson					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS			
No		181-07-3171		Z. W. Sanders		Carlisle, Pa. 17013			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		CORONARY THROMBOSIS (acute) Sudden		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
-1109		DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF					
		(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH		P.M. 19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL EXAMINER'S NAME (Type)		22b DATE SIGNED		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
William Speiches		6-21-69		1355 Westminister		Littlestown, Adams Co. Pa.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)			
Burial		6/25/69		St. Aloysius Cemetery		Littlestown, Adams Co. Pa.			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Richard A. Little		Littlestown, Pa.		DATE JUN 25 1969		Charles Judge			



4409

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08251		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08244		
1 DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR P
Joseph Alden Schissell				SCHIESSL			6-8-69	11:00
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS.
Male	White	8-5-89		87 YRS		MONTHS		DAYS
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Wisconsin		U.S.A.				Carroll Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Sykesville		Springfield St. Hospital		Retired				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland		Montgomery		Potomac		10,000 Carmelita Drive		
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown (If yes give war or dates of service)		16b SOCIAL SECURITY NO		
Joseph Schissell		Margaret YEAGER		None		327-07-0860		
17 INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Springfield St. Hospital Records, Sykesville, Md.		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Uremia</u>		DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		GPS assoc. with cerebral arteriosclerosis with psychotic reaction		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that this hospital attended the deceased from 4-29-69, 19, to 6-8-69, 19, that (X) (we) last saw the deceased alive on 6-8-69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death		22b. SIGNATURE Jose A. Raquel Jr. M.D.		22c. DATE SIGNED 6-8-69		22d. PHYSICIAN'S NAME (Type) Jose A. Raquel, Jr. M.D.		22e ADDRESS Springfield St. Hospital, Sykesville, Md.
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 6-12-69		23c NAME OF CEMETERY OR CREMATORY HOLY SEPHULCHRE CEM		23d LOCATION (City or Town) (County) (State) OAKLAND, ILL		24 FUNERAL DIRECTOR W.W. CHAMBERS CO ADDRESS 1400 CHAPIN ST. N.W. WASH. D.C.
25a REC'D BY REGISTRAR JUN 12 1969		25b REGISTRAR'S SIGNATURE Charles J. J...		25c REGISTRAR'S SIGNATURE		25d REGISTRAR'S SIGNATURE		25e REGISTRAR'S SIGNATURE





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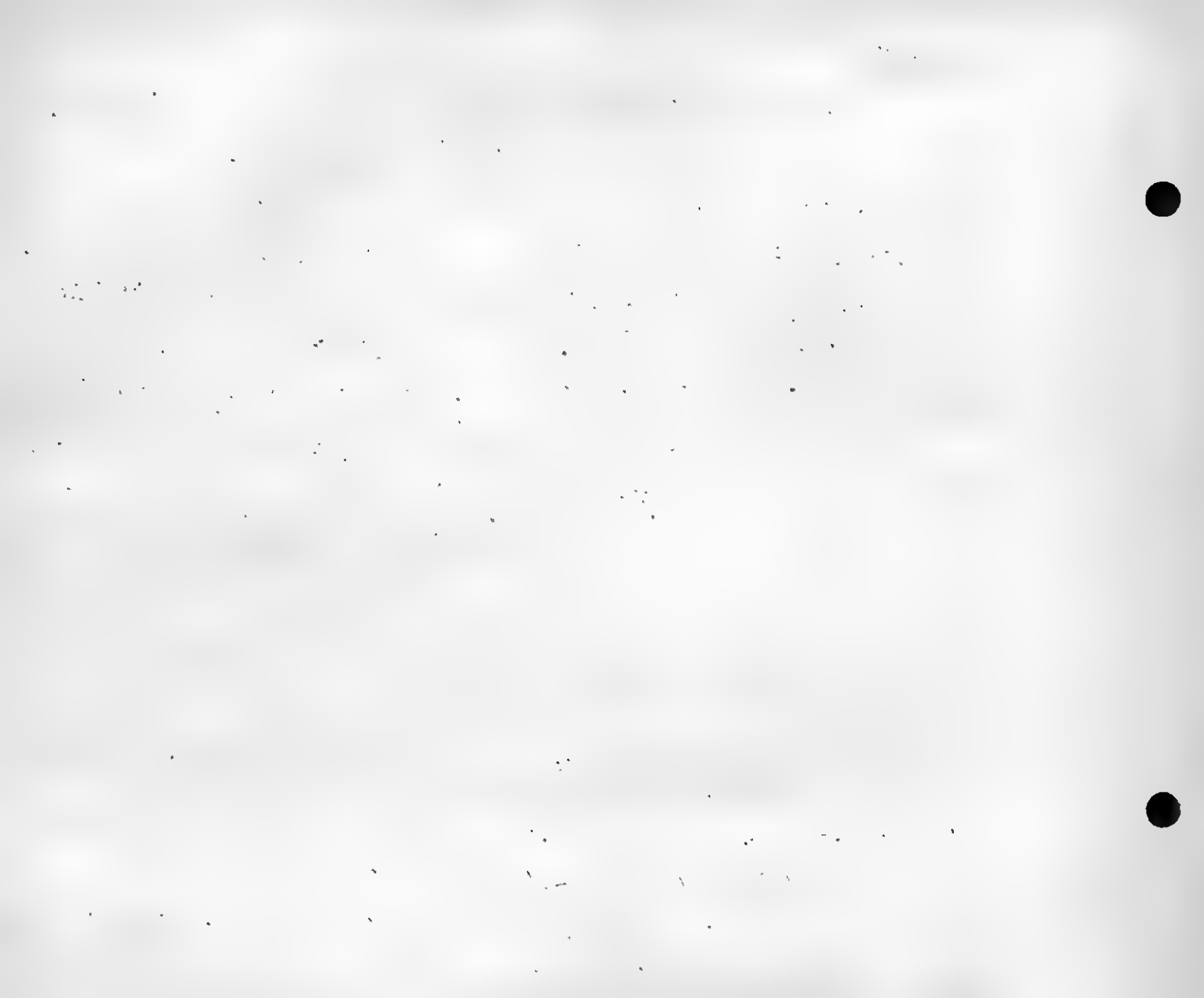
CERTIFICATE OF DEATH

08252

08245

1 DECEASED NAME (Type or print) <b>OLIVER CORNELIUS SHOLL</b>			2a. DATE OF DEATH Month <b>6</b> Day <b>21</b> Year <b>69</b>			2b. HOUR <b>1:00</b> M				
3 SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>NOV. 4, 1882</b>		6. AGE (In years last birthday) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>CARROLL Co.</b>				
10 CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>R.F.D. #4</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CARE TAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STATE HOSP.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY, J.M.T.S? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <b>R.F.D. #4 CRANBERRY</b>		
14 FATHER'S NAME First Middle Last <b>JOHN W. SHOLL</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>REBECCA FRS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>NO</b>			16b. SOCIAL SECURITY NO <b>219-12-0562</b>		17. INFORMANT <b>MISS HELEN H. SHOLL</b>				Address <b>WESTMINSTER, RT #2, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (anti)</b> <b>41100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension + Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>1-22</b> 19 <b>64</b> , to <b>6-21</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>6-21</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>W. Glenn Speicher MD</b>				22c. DATE SIGNED <b>6-21-69</b>		22d. PHYSICIAN'S NAME (Type) <b>W. GLENN SPEICHER MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6/24/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST MARKS CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>SILVER RUN, CARROLL, MD</b>				
24. FUNERAL DIRECTOR <b>J. S. Myers, Westminster, Md 21157</b>				25a. RECEIVED BY REGISTRAR <b>JUN 24 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

MEDICAL CERTIFICATION

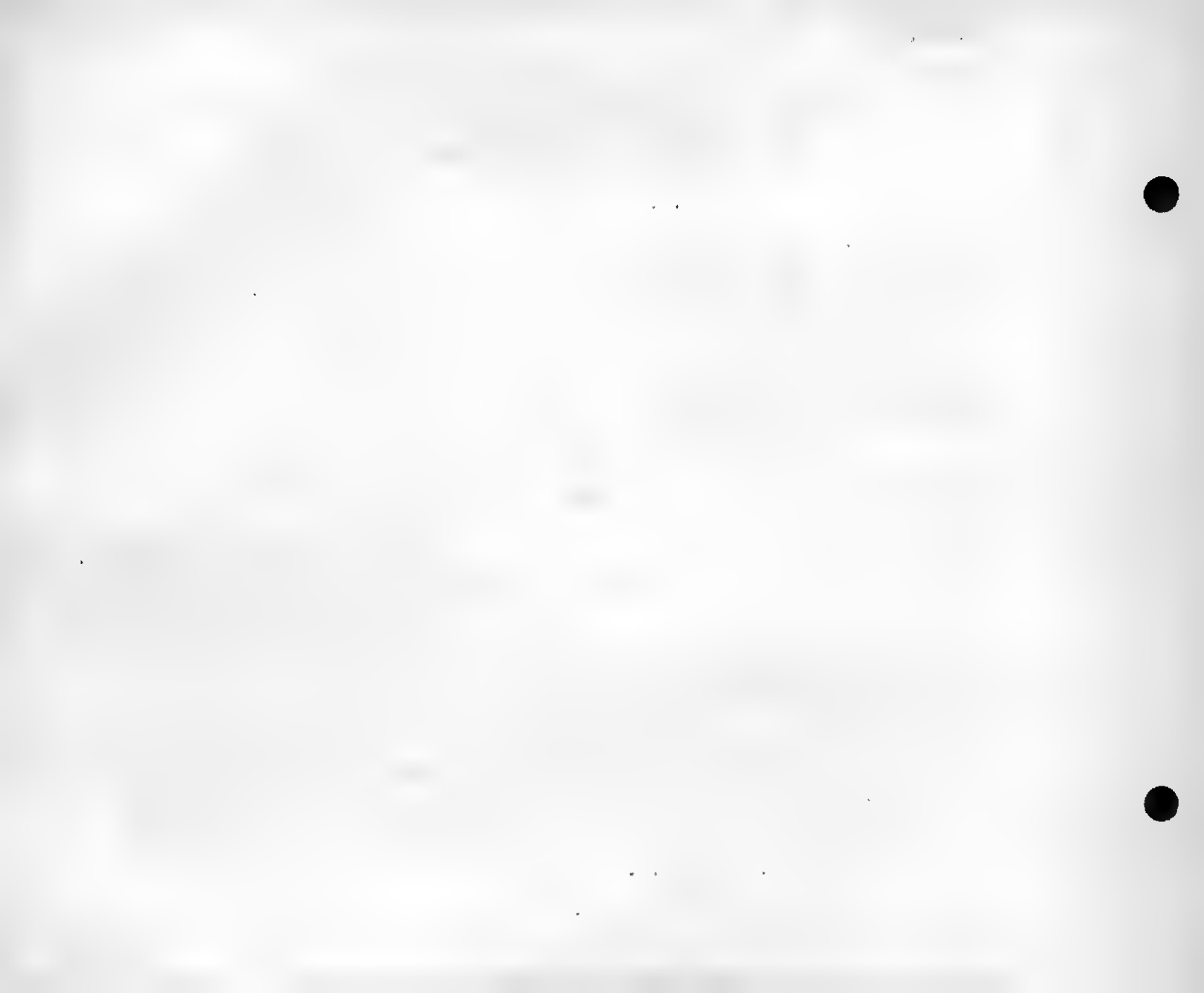


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45M 1969

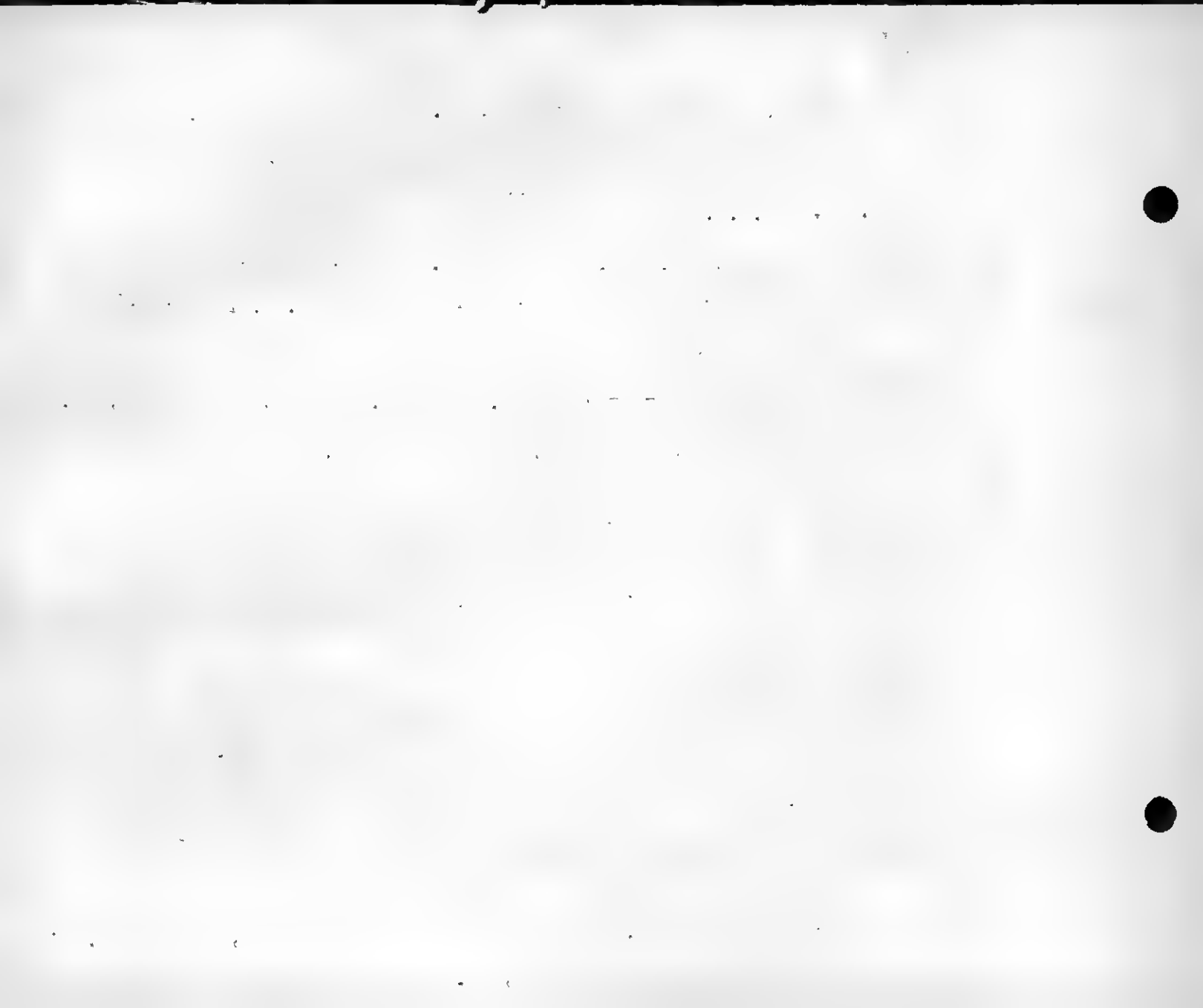
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR
GODFREY			BERNARD	SMITH	JUNE 6- 1969			7:15	AM
3 SEX	4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White		7-31-02			66 YRS			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland			U.S.A.					Carroll Md.	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Sykesville			Springfield State Hospital			Unknown			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY (Y/N) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Baltimore City			Baltimore		307 Sharp Street (?)	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Bernard					Smith	Annie			Burns
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT Address			
No			217-32-8089			Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									Weeks
IMMEDIATE CAUSE (a) <u>Gangrene of both feet</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Severe occlusive arteriosclerotic peripheral</u>									Month
DUE TO, OR AS A CONSEQUENCE OF <u>vascular disease</u>									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CBS assoc. with alcohol intoxication, without qualifying phrase									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)			21f. LOCATION Street or RFD No		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>10-18-54</u> , 19__, to <u>6-6-69</u> , 19__, that (I) (we) last saw the deceased alive on <u>6-6-69</u> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Octavio A. Ruiz, M.D.</u>					DEGREE	ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <u>6-8-69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Octavio A. Ruiz, M.D.</u>					22e. ADDRESS <u>Springfield State Hospital</u> <u>Sykesville, Maryland 21784</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
<u>Burial</u>			<u>6-16-69</u>		<u>St. Michael's Cemetery</u>		<u>Baltimore</u> <u>MD</u>		
24. FUNERAL DIRECTOR <u>Frederick A. [illegible]</u>					ADDRESS		25a. REC'D BY REGISTRAR DATE <u>JUN 18 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[illegible]</u>



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Ernest Wilmer Stewart, Sr.						Month Day Year		3:05 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR		
Male		White		7/23/1889		79 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
Carroll Co. Md.		U.S.A.				Carroll				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Westminster			Carroll Co. General Hosp.			Retired Farmer		Farm		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm ssion) STATE			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13b. STREET AND NUMBER			
Maryland			Carroll		Westminster YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R. D. 1		21157	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
Joshua Stewart			Ida Crowl							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17 INFORMANT Address					
No			219-20-4467		Mrs. Elvira V. Stewart, Westminster, Md. R-1					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ATHEROSCLEROTIC CORONARY HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF <u>4</u> YEARS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 MO.</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>RHEUMATIC HEART DISEASE</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>5/23</u> , 19 <u>69</u> , to <u>6/25</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/25</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
<u>Vincent J. Gioia</u>				MD				6/25/69		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6/27/69		St. Marys Cemetery		Silver Run, Carroll Co. Md.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REG STRAR		25b. REG STRAR'S SIGNATURE		
<u>Richard A. Little</u>				Littlestown, Pa.		DATE JUN 27 1969		<u>Charles Judge</u>		



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08255		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08248	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <b>James B Wheeler</b>			2a. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>1969</b>		2b. HOUR <b>9:15</b> <sup>AM</sup>		
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>7 or 21, 1888</b>		6. AGE (In years last birthday) <b>80</b> YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md	
10. CITY OR TOWN OF DEATH <b>Manchester, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Longview Nursing Home, Manchester</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>self employed.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Greenmount</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>none.</b>		14. FATHER'S NAME First <b>William T.</b> Middle <b>Wheeler</b> Last <b>Wheeler</b>		15. MOTHER'S MAIDEN NAME First <b>Henrietta</b> Middle <b>W.</b> Last <b>Smallwood</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no.</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>218-09-1104</b>		17. INFORMANT <b>(daughter) Mrs. Charles Heish Greenmount, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>451.1</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b> <b>2 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 1950</b> , to <b>June 25, 1969</b> , that (I) (we) lost saw the deceased alive on <b>June 24, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE <b>W. H. Foard</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6/25/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>W. H. Foard MD</b>		22e. ADDRESS <b>MANCHESTER, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/28/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Greenmount, Md. Carroll Md.</b>	
24. FUNERAL DIRECTOR <b>John E. Goff</b>		ADDRESS <b>324 N. Main Street</b>		25a. REC'D BY REGISTRAR <b>John E. Goff</b>		25b. REGISTRAR'S SIGNATURE <b>Richard L. Judah</b>	
John E. Goff Funeral Home		Hampstead, Maryland		DATE <b>JUN 30 1969</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

08256

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08249

1. DECEASED-NAME (Type or print) <b>Willie</b>		First		Middle		Last		2a. DATE OF DEATH Month <b>JUNE</b> Day <b>1</b> Year <b>1969</b>			2b. HOUR <b>12 P M</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 17, 1890</b>				6. AGE (In years last birthday) <b>78</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>1</b>		8. IF UNDER 24 HRS HOURS <b>12</b> MIN. <b>00</b>	
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b> Md.							
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>R 3, Box 388</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Sykesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
14. FATHER'S NAME <b>Eli Pinkley Wilson</b>				First		Middle		Last		15. MOTHER'S MAIDEN NAME <b>Mary Corey</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>237-24-5154</b>		17. INFORMANT <b>Mrs. W. P. Wilson</b>		Address <b>R 3, Box 388, Sykesville,</b>		Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: <b>4109</b> IMMEDIATE CAUSE (a) <b>A S H D, Coronary thrombosis, Cerebral vascular</b> DUE TO, OR AS A CONSEQUENCE OF <b>accident, Arteriosclerosis, general-</b> <b>ized, Cardiac failure.</b> DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death <b>2 years</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Howard E. Hall</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6/2/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Howard E. Hall, M. D.</b>		22e. ADDRESS <b>Sykesville, Maryland 21784</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6-4-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pinewood Memorial Park</b>		23d. LOCATION (City or Town) <b>Greenville,</b>		(County) <b>Pitt</b>		(State) <b>NC</b>			
24. FUNERAL DIRECTOR <b>S. G. Wilkerson &amp; Sons, Greenville, NC</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>JUN 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 4,5 Film **DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**7/1/69 11w 08257 CERTIFICATE OF DEATH**

08250

1. DECEASED-NAME (Type or print) <b>JOHN LEE WOODYARD</b>			2a. DATE OF DEATH Month <b>6</b> Day <b>22</b> Year <b>69</b>			2b. HOUR <b>10<sup>35</sup> PM</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b> Negro		5. DATE OF BIRTH <b>DEC 18 1895</b>		6. AGE (In years last birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>GARROLL Co.</b>	
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GARROLL CO. GEN. HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>GROWER FLORIST</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>GARROLL WESTMINSTER</b>			13c. CITY OR TOWN <b>WESTMINSTER</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>MARTIN</b> Middle <b>LUTHER</b> Last <b>WOODYARD</b>			15. MOTHER'S MAIDEN NAME First <b>AUGUSTUA</b> Middle <b>SQUIRREL</b> Last			16a. WAS DECEASED EVER IN U.S. ARMED SERVICES? Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>215-20-9695</b>	
17. INFORMANT Address <b>SAME ADDRESS</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MULTIPLE MYELOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b> <b>WEEKS</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>6/20</b> , 19 <b>69</b> , to <b>6/22</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>6/22</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Vincent J. Fiocco, Jr. MD</b>			22c. DATE SIGNED <b>6/22/69</b>			22d. PHYSICIAN'S NAME (Type) <b>VINCENT J. FIOCCO, JR. MD</b>				
22e. ADDRESS <b>ANCHOR ST. WESTMINSTER MD</b>			23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>6/25/69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>FAIRVIEW CEMETERY</b>	
23d. LOCATION (City or Town) (County) (State) <b>FREDERICK MD</b>			24. FUNERAL DIRECTOR <b>J. S. Myers, Jr. Westminster, Md.</b>			25a. REC'D BY REGISTRAR <b>J. Charles Judge</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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